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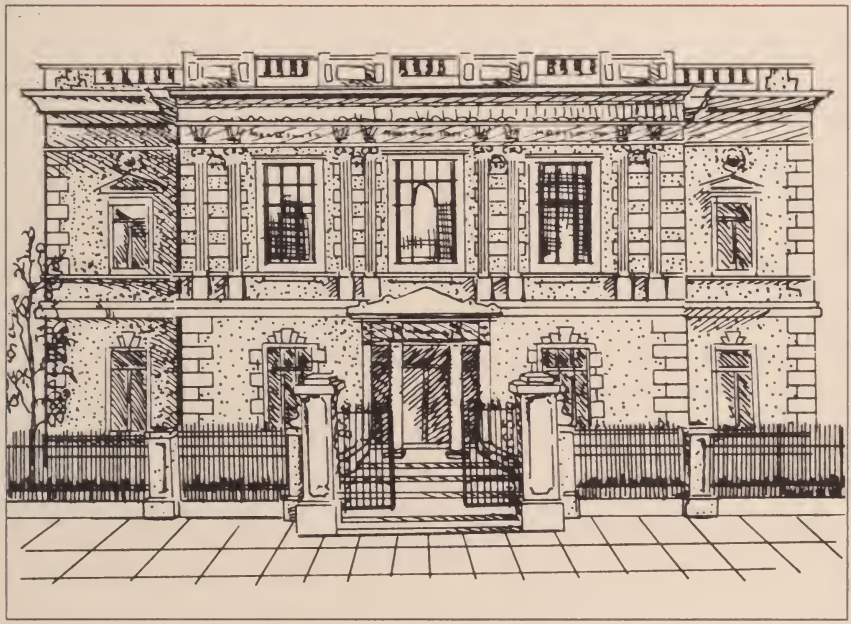

of the
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

Series V Volume XXIII December 2001

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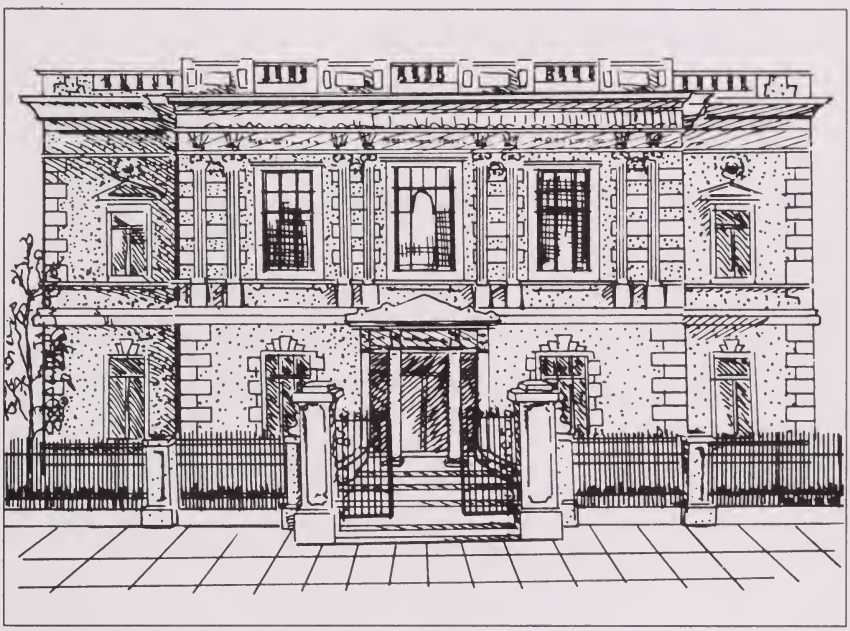

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OF THE
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Editorial

This special issue of *Transactions & Studies of the College of Physicians of Philadelphia* is devoted to presidential disability and the 25th Amendment. It represents the culmination of a five-year effort by the College to help educate the medical profession, the public and policymakers about a subject that many in official Washington are skeptical about. The key elements of this initiative have included a major exhibition in the College Gallery (a modified version of this exhibit is on permanent display in the College's Museum); a lecture series; the 1997 Forum on Presidential Disability, which began with a keynote address by U.S. Senator Arlen Specter (R-PA) and featured a review of the historical evidence by leading physician-historians, and an in-depth study of the subject by the College's Task Force on Presidential Disability. The catalogue for the exhibition, Senator Specter's remarks, and the final report issued by the Task Force all appear in this volume.

To better understand why this subject is important not just to physicians, but to all those who believe in constitutional democracy, a brief review of the historical record may be helpful. We now know that President Washington nearly died twice during his eight years in office. More surprising still is the fact that fully half of his successors experienced serious health problems while in office.

As the nation's oldest medical academy, it is one of our historic responsibilities to point out that, contrary to popular belief, many chief executives receive sub-standard medical care, which includes, but goes beyond, questions of individual medical competence. When a physician examines an average patient, he or she follows a standard protocol that reflects practice guidelines that have evolved over years of collective experience. Given the great authority that the president wields and the incredible demands on his or her time, it can be very difficult for physicians to perform such protocols on a presidential patient. In emergency situations, the problem is compounded by chain of command issues and interference from family members and political associates. (The autopsy of John F. Kennedy and the emergency medical care provided to Robert F. Kennedy following his shooting

in Los Angeles starkly illustrate these problems.) The irony is that an ordinary citizen may sometimes receive better care than the president of the United States. If some of this seems hard to believe, remember that the president may be the only employee in the U.S. not entitled to an independent, third-party review if he or she is seriously ill or injured on the job. Treating such a patient is difficult in part because the physician can quickly find himself or herself enmeshed in conflicts of interest. When the national interest and the interest of the president as a patient conflict, where do the physician's ultimate duties lie? Following President Eisenhower's heart attack in 1955, his cardiologist, Dr. Paul Dudley White, was of the opinion that the president should not seek a second term. He soon discovered that this important decision would be driven by political rather than medical concerns. Eventually, Dr. White was forced to sign a public document endorsing the idea that the president was healthy enough to run again. Franklin D. Roosevelt was clearly a dying man when he was re-elected to a fourth term in 1944. Once again, political considerations trumped medical concerns.

The long-established tradition of using military physicians to provide routine, day-to-day care for the president adds another dimension to the conflict-of-interest issue. These doctors take an oath to protect the interests of individual patients, but they also promise to follow the orders of their superiors in the chain of command. The Constitution makes clear that since the president is the commander-in-chief of the armed forces, the nation's highest-ranking military officers must defer to him or her. However, making the president dependent on military physicians for routine care may also dilute presidential authority.

What can be done to address the conflict-of-interest issues raised above while simultaneously strengthening the authority and independence of the White House physician? Mandating a second opinion on the president's health from an independent panel of medical specialists may be the most effective answer. Sensitive to the need to balance the national interest, the president's rights as a patient, and the public's right to know, we envision that the panel would conduct its work quietly, and in most cases, beneath the media's radar screen.

It is often suggested that the combination of television and a multi-channel, multi-media 24-hour news cycle has significantly reduced the ability of a president to mislead us about the state of his or her health. This is a comforting fiction, which history has already disproved. While it is true that no future president will be able to vir-

tually disappear for months at a time as the ill Wilson did in 1919, or the injured Garfield did in 1881, the need to distinguish between genuine openness and better stage management remains important. In fact, television and the more sophisticated techniques of presentation that followed have played an important role in allowing presidents and their aides to mislead the public. Some experts believe that the modern era of mass communication begins not with the presidential campaign of 1952, but with President Eisenhower's heart attack three years later. By orchestrating multiple televised briefings for the media on a regular basis, Press Secretary Jim Hagerty was able to create the appearance of openness, while effectively withholding information that he did not want the media or the public to have. It may be no accident that following his years in the White House, Hagerty became the president of ABC News.

Following the shooting of President Reagan in 1981, his aides did not want the public to realize how frail the president actually was or how close he had come to dying. By making the most of the president's command of stagecraft and carefully controlling the images that appeared on television, the true state of Reagan's health and the compromised quality of the emergency care he received did not become public knowledge for years.

Future historians may wish to study a now-forgotten episode of the Clinton presidency. During a visit to the Florida estate of golf pro Greg Norman, the president apparently fell down a flight of stairs in the middle of the night, injuring his leg in the process. While the president's injury was ultimately not significant, the incident is instructive because a gap of several hours occurred between the accident itself and the time that the press became aware that anything out of the ordinary had occurred.

Just as some believe that television has checked the ability of the president to deceive the public about the state of his health, others feel that the 25th Amendment to the Constitution has solved the problem of dealing with a president who is alive, but incapable of carrying out official duties. Ratified just four years after the assassination of President Kennedy, the amendment attempts to address this problem through a series of related legal steps. First, it provides a legal framework for nominating and confirming a new vice-president if the office is vacant. When Gerald Ford became president following the resignation of Richard Nixon in 1974, he invoked this provision to select Nelson Rockefeller as his vice-president. The amendment also allows a chief executive to transfer the power of the presidency to the vice-president on a temporary basis and reclaim it

later. The record on this article is mixed. President Reagan used this provision at least once that we know of. However, since the president endured a number of surgeries under anesthesia during his two terms in office, some historians feel that he could have invoked this provision more frequently. No president can afford to be perceived as weak or unable to lead. This suggests that future leaders may be reluctant to invoke this article if it can be avoided.

The most controversial portion of the 25th Amendment has never been tested. It outlines a process through which a president can be declared incapable of carrying out the duties of his or her office and power passes involuntarily to the vice-president. The process begins when a majority of the cabinet (including the vice-president) or some other body which Congress may by law provide, votes in favor of such a declaration. Such a decision must be confirmed by a two-thirds vote in each house of Congress. This approach seems problematic.

Cabinet members owe their jobs and whatever benefits may accompany them to the president. In addition, most share a longstanding commitment to the success of the president's political party. This combination of factors will make it very difficult for cabinet members to help end the political career of such an important patron. The conflicted position of the vice-president, who will be the prime beneficiary if the president is forced from office, is the most awkward of all.

Following President Wilson's massive stroke in 1919, Secretary of State Robert Lansing attempted to have Wilson removed from office. Not a single cabinet colleague would support this initiative and Lansing himself was quickly fired for insubordination. The language of this article suggests that Congress itself had doubts about the wisdom of asking cabinet members to make a judgment about the president's ability to serve. The College of Physicians believes that this decision should be a medical, not a political decision. An independent panel of medical specialists represents the best opportunity to help correct a problem that has shadowed our nation since the administration of George Washington and continues to be a potential threat to national stability and world peace.

MARC S. MICOZZI, M.D., PH.D.
EXECUTIVE DIRECTOR

Transactions of the
College of Physicians of Philadelphia

Annual Report of the President*

The president of the United States is required by the Constitution to report annually on the state of the union. A president of the College has a little more discretion and tonight I will present the College's annual report. FY2001 has been a time of remarkable accomplishment and change at this institution. It illustrates what can be achieved when governance, the Fellowship, and staff work together to achieve common goals.

People of different political persuasions agree that last summer's Republican National Convention was a great benefit to Philadelphia and the Delaware Valley at large. The historical record indicates that Philadelphia has had the opportunity to host a national convention once every 50 years. I am proud that the College seized this important opportunity and made the most of it. We know that approximately 100,000 people saw a special version of the College's presidential health exhibit at the Pennsylvania Convention Center during "Politicalfest," the world's fair of politics that accompanied RNC 2000. Many other visitors saw a different version of this exhibit that was on display in the Mütter Museum during the Convention—and if you have not yet had a chance to do so, I invite you to see it this evening.

Due to a combination of free media attention and limited promotional activity, the College achieved saturation media coverage during this period. The combination of the presidential health exhibit and the Museum itself proved to be irresistible. *Time* and *Newsweek* took notice and we were in the local papers or on television every single day. Now, the skeptics among you may be asking if this really matters. It is interesting to note that in the weeks and months since the convention, the number of visitors coming to see our Museum, Gallery, and the newly named Benjamin Rush Medicinal Plant Garden has increased nearly 40%. No review of the RNC is complete without my mentioning that the *National Review* held its 50th Anniversary Gala here and RNC delegations from Oklahoma and Arkansas also held their official convention receptions at the College.

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*Presented at College Night, May 23, 2001.

This is an appropriate occasion to say something about the demands of good stewardship. Any history of educational and cultural institutions in Philadelphia includes the names of worthy organizations that no longer exist. It is often said that aviation is a field where there is little tolerance for incapacity or neglect. Well, the same principle applies in the realm of sound financial management. All of us can take pride in the fact that we have made both the tough choices and the real sacrifices that fiscal discipline requires. Now, we have come to the point in the process where the fruits of our labor become visible. The College has experienced much improved fiscal health this year. We currently have an operating surplus and we have not had to draw excess distributions from our endowment to support operations as we have had to do in the past. I am particularly pleased that the College's spending rule, once as high as 9%, is now down to 6%. Next year, it will drop to 5.75%. This is also a good time to salute the College's new chief financial officer, Mr. John Sawyer. John joined us less than a year ago, and he is one reason that we remain firmly committed to the path of fiscal prudence.

A second and equally important mandate of good stewardship is to take proper care of the remarkable building that houses all our treasures. The College has embarked on the first phase of a major building renovation program which, when complete, will extend the useful life of our home for many decades. This initiative is supported in part by grants from the federal government, the Commonwealth of Pennsylvania, the McLean Contributionship, the Arcadia Foundation, and Fellowship contributions. The scope of the work to be completed in this phase includes:

- Replacement of the heating, ventilation and air conditioning (HVAC) system for the Library stacks, ductwork, and interior walls. The new HVAC system is a major part of the Library's conservation efforts.
- Restoration of all windows and exterior doors to their original appearance.
- Cleaning and restoration of the façade of the exterior of the building on all four elevations.
- Restoration of this hall [Mitchell] which will include all lighting, refurbishing the floor and woodwork, and an improved sound system.
- Additional related projects such as cleaning of the marble interiors will be added if additional capital funds are raised.

This was also a year of significant progress and change for the College's Division of Public Services. For the first time in history, the College opened to the public on Sundays, and uniform, seven days a week, public hours of 10:00 A.M. to 5:00 P.M. were established. This change, coupled with a more realistic policy on admission discounts produced a 48% increase in Museum revenues. The College's public facilities were highlighted in a wonderful new brochure. Included as part of this package were new publications providing information about the Museum and the C. Everett Koop Community Health Information Center (CHIC).

The College continued to be an enthusiastic participant in Philadelphia's "Adopt a School" program, as it has for a decade. The College has adopted the Vare Elementary School in South Philadelphia and Gratz High School in North Philadelphia. Working in partnership with the University of Pennsylvania, the College is forging ties with public schools in West Philadelphia as well.

The College continued to work with the Philadelphia School District to improve science literacy, career education and the knowledge of medical history. This effort, which is funded by a grant from the U.S. Department of Education, also produced a series of innovative workbooks for classroom use, which focused on genetics and nutrition. The CHIC also received a grant from the CDC that will allow it to implement the recommendations of an earlier evaluation by the CDC.

This fiscal year also witnessed important changes for the College's Library and Wood Institute for the History of Medicine. Dr. Edward T. Morman was selected as the new College Librarian and Director of the Wood Institute. Dr. Morman, who was formerly associated with the New York Academy of Medicine, will be the first occupant of the endowed Measey Chair in Medical History. The terms of this arrangement will draw the College even closer to Philadelphia's four medical schools, as Dr. Morman will teach the history of medicine at those institutions.

In other related developments, the Library will soon complete the Historical Medical Digital Library, which will make many of our greatest treasures more accessible to an international audience. This work was funded by a National Leadership Grant from the federal Institute of Museum and Library Services. We are also very proud of a new grant that the Library has received from the Barra Foundation making it possible for the Library to purchase a new state-of-the-art cataloguing system. If you love the Library as I do, you have noticed

that the Library is featured in a splendid new brochure of its own, which we have in the Library.

Such a report would not be complete without mentioning the remarkable and accomplished figures in public health, clinical medicine, medical ethics, and the history of medicine who come to us via the College's continuing series of public programs. Over the past year, the notables who have spoken at the College include: the noted health economist, Dr. Uwe Reinhardt; CDC Director Dr. Jeffrey Koplan; Nobel Laureate Dr. Joseph Murray, who spoke here in honor of Dr. Jonathan Rhoads's 94th birthday; and scientist and laboratory director, Dr. Hilary Koprowski. Next year's lecture series speakers will be similarly prominent.

Finally, mention need be made of the strategic planning process chaired by President-Elect Dr. Thomas Langfitt that began last September and will continue throughout the year. Every aspect of the College is being carefully evaluated in an effort to produce a stable and vital institution with a great historical tradition. The last such review occurred more than five years ago and led to several positive changes, which we trust will be the result of the present activity.

The College of Physicians of Philadelphia has faced many challenges since 1787. Today, it is vibrant, dynamic, and ready to face new challenges. As I stand before you this evening, I am convinced that for the College, the best is yet to come. Thank you.

ALLEN R. MYERS, M.D.
PRESIDENT

Annual Report of the Executive Director FY2001

Public Programs and Policy

Since the Republican National Convention brought renewed local and national attention to the College's exhibit on presidential disability and to the Mütter Museum generally, visitation and revenues have increased by 40 percent. In part, the growth in attendance can be attributed to policies that were implemented prior to the Convention. These include opening the Museum seven days a week for the first time in history and extending operating hours until 5:00 P.M. daily. The progress of the College's historic building renovation project required that the College's front entrance be closed for a time in May. Visitors and staff were rerouted to the rear entrance in May. No safety, security, or logistical problems occurred.

A new, state-of-the-art brochure promoting the College's Benjamin Rush Medicinal Plant Garden was printed with the support of the Groff Trusts and other donors. The Garden remains a rich source of potential naming opportunities for the College.

The Board approved a new Gallery exhibition for 2003, *Only One Man Died: Medical Adventures on the Lewis & Clark Trail*, that will focus on the theory and practice of medicine in 1800 in coordination with the Lewis and Clark Bicentennial Commemoration. The College will draw on the collections of the University of the Sciences in Philadelphia (formerly the College of Pharmacy and Science), the University of Pennsylvania Museum of Anthropology and Archaeology, the Rosenbach Library, the American Philosophical Society, and other local and national institutions to mount an important exhibition that will be of interest to the general public and physicians. Among the other institutions helping the College promote the exhibition are the Philadelphia Zoo and the New Jersey State Aquarium. The College is also coordinating with the Philadelphia Convention and Visitors' Bureau and the Academy of Natural Sciences as part of this initiative.

The College was invited by the *American Medical News* to submit a series of twelve columns that illuminate major themes in medical history and the culture of medicine by exploring the treasures of the College's Library, Museum, and fine arts collections. Columns in the series published to date have focused on such diverse subjects as Dr. Benjamin Rush's chest and the original charter of the American Medical Association, itself. Columns for this series are authored by College staff and Fellows, such as Dr. Luther Brady.

Wood Institute and Historical Library

Edward T. Morman, M.S.L.S., Ph.D., became College Librarian and Director of the Francis C. Wood Institute for the History of Medicine, occupying the new Measey Chair in Medical History as of July 1, 2001. The Measey Foundation pledged a gift of $1.9 million to the Wood Institute to support the new Chair. The first installment of this gift was received. Dr. Charles Rosenberg was named as the recipient of the College Award for Meritorious Service for his leadership while chairing the search committee for the new Wood Institute and Historical Library chief. In March, the College submitted a proposal to the William Penn Foundation for a three-year grant of $640,000 for conservation, cataloguing, preservation, and dissemination about the College's Historical Library, to be awarded in late July.

Financial Management

In FY2001 the College returned a $100,000 cash operating surplus to the endowment. A balanced budget for FY2002 was prepared by management and approved by the Board. The College conducted an extensive review of its Library, Museum, and fine arts collections to make sure that they were insured appropriately. With the help of Dr. Luther Brady, Christie's of New York City was engaged to conduct this review. As part of this process, the College's holdings and insurance needs were compared with those of major museums and cultural institutions throughout the nation. A change in the institution's insurance carrier resulted in savings to the College of $16,000.

Public Services

At the invitation of the CDC, the College submitted a request for a non-competitive renewal for the second year of a grant to expand the College's C. Everett Koop Community Health Information Center (CHIC) and to implement the College's partnership with the Free Library of Philadelphia. The College will recover all of its direct costs for the CHIC. The College investigated the feasibility of support for a regional community health information system to serve the Delaware Valley through referrals from intermediaries such as the public library system, the public school system, and physicians' offices. This model would include a variety of other local resources in addition to the Free Library of Philadelphia, and would have the potential to become a national model. The College also anticipates a second grant from the federal Fund for the Improvement of Education (FIE) to continue our museum-based school education program. A grant to the Health Resources and Service Administration Bureau of Health Professions (HSRA/BHP) for a health careers school education program was also investigated. Meetings were held with local and national HRSA/BHP leadership to identify existing health career school programs that could benefit from inclusion of the College's museum-based informal education resources and mentors from the College's professional staff and Fellowship. In connection with these discussions, College officials reviewed their experience of attempting to establish a physician volunteer "mentor" program.

Building Renovations

During the College's most extensive building renovations in decades, major steps were taken to enhance and make the best use of the College's physical environment. As part of this process, a state-of-the-art environmental control system was installed in the Library stacks, which will also help the Museum; exterior windows and doors were restored to their original form and function; the building's facade was cleaned and repaired; and an ambitious plan to restore Mitchell Hall to its original status as one of Philadelphia's grand halls was implemented. The master plan for Mitchell included significant improvements in many areas, including lighting, floor, woodwork, plaster, painting, and state-of-the-art sound and AV systems. The College embarked on a detailed, multi-part oversight program that included:

(1) additional oversight from the vice-president at Arena & Co., without an increase in management fees; (2) a formal review of the project from a historic preservation perspective with Arena & Co., by the Hillier Group, primarily on a pro bono basis; (3) review of the overall structure of construction contracts and procedures by attorney and College Fellow E. Gerald Reisenbach, Senior Partner of Cozen and O'Connor; (4) interviews by management with individual staff members regarding on-site observations of construction work; (5) daily or every-other-day briefings with the Executive Director, Antonia Oberthaler (Director of Executive Office and Institutional Advancement), and Joe Tomasco, On-Site Project Superintendent (Arena & Co); and weekly or bi-weekly updates to President Myers and Administration Committee Chair, Robert Campbell.

MARC S. MICOZZI, M.D., PH.D.
EXECUTIVE DIRECTOR

Annual Report of the Section on Medical History

The Section on Medical History, founded in 1905, also functions as the Philadelphia Chapter of the American Association of the History of Medicine. During the past year we offered a series of four lectures, including one co-sponsored with the Section on Arts-Medicine.

The Samuel X Radbill Lecture on October 11, 2000, was given by Peter C. English, M.D., Ph.D., Professor of Pediatrics and Professor of History at Duke University. Dr. English also is the Josiah Charles Trent Professor of the History of Medicine and the Associate Director for Academic Affairs at the Center for the Study of Medical Ethics and Humanities at Duke. Dr. English discussed "*Rheumatic Fever: Its Emergence and Disappearance*," emphasizing the changing clinical picture of rheumatic fever. The occasion of the 2000 Radbill Lecture also marked the official relocation of the Samuel X Radbill Pediatric Historical Library from the Children's Hospital of Philadelphia to the Historical Library at the College of Physicians of Philadelphia and the publication of the accompanying Catalogue. To mark the event, Donald Schwarz, M.D., Interim Physician-in-Chief attended and addressed the enthusiastic audience. The staffs of the Library and Mütter Museum prepared a display of items from the Radbill Collection and the Children's Hospital of Philadelphia sponsored the reception and dinner, which were attended by both of Dr. Radbill's daughters, Gloria Hamilton of Swarthmore, PA, and Estelle Brearly of Washington, D.C.

On November 11, 2000, a series of lectures on the history of anaesthesia in Philadelphia was presented by three Section members: Samuel Tirer, M.D., Clinical Assistant Professor of Anaesthesia at the University of Pennsylvania and Staff Anaesthesiologist at Presbyterian Hospital, discussed *Rivalries and Controversies during Ether Anaesthesia*; Henry Rosenberg, M.D., Professor of Anaesthesia at Thomas Jefferson University, discussed *Henry Ruth and Robert Hingson and their Influence on Medicine*; and John Downs, M.D., Director of Rehabilitation Services of the Children's Hospital of Philadelphia, detailed the history of *Pediatric Anaesthesia at the*

Children's Hospital of Philadelphia. The meeting was well-attended by both Section members and members of the Philadelphia Anaesthesia Society.

On March 7, 2001, the Kate Hurd Mead Lecture was given by Susan Welles, Ph.D., Professor of English at Temple University. Professor Welles's talk on *Mary Putnam Jacobi and the Speaking Picture* provided insight into the background and life of an early student at what was then the Women's Medical College and the completion of her medical training in Paris. The lecture was given at the Medical College of Pennsylvania and attended by faculty, staff, and students, as well as members of the Section.

On April 25, 2001, the Section co-sponsored with the Section on Arts-Medicine a lecture by David Cast, Ph.D., Professor of Art History at Bryn Mawr College and an internationally respected art-historian, on *The Medical Drawings of Leonardo da Vinci: Failures and Successes*. Professor Cast described the political and social background of the medical drawings by Leonardo da Vinci; ample illustrations revealed that the two sets of medical drawings were influenced not only by political and social changes but also by da Vinci's exposure to anatomical dissections.

A. Deborah Goldstein, M.D., Ph.D.
Chairman, Section on Medical History

Annual Report of the Section on Public Health and Preventive Medicine

It is my pleasure to report that the Section on Public Health and Preventive Medicine of the College of Physicians of Philadelphia has had another productive and active year, 2000–2001. The Executive Committee of the Section includes: Ann O'Sullivan (Clerk), Allen Myers, Walter Tsou (Past Chair), Charles Lee, Sindy Paul, Lewis Polk, Luc Van Parijs, John Maher, Robin Wilcox, Robert Gage, Alice Hausman, Maureen Hennessey Herman, Robert Sharrar, Rosemary Nolan-Hamm, Patricia West, Bennett Lorber, Paul Fink, and Alfred Fishman. The Section is particularly indebted to Susanne Eagleson, the Secretary, and our staff liaisons Andrea Kenyon and Sofie Sereda.

The Section has focused significant energy on a number of public health policy issues. Over the past year we have discussed in detail the "tobacco settlement" and have communicated with State policymakers, offering the assistance of the College and the Section in their deliberations. In this process we have provided information on the importance of utilizing tobacco settlement funds for public health issues in our communities. The Section's Executive Committee also reviewed policy issues, including pharmaceutical advertising, access to care, and other crucial public health concerns. As we have in the past, the Section held a series of programs throughout the year.

On September 28, 2000, we co-sponsored with the Institute for Safe Families of Philadelphia a talk by Ann Ganley, Ph.D., entitled, *Responding When Your Patient is a Domestic Violence Perpetrator.* On October 25, 2000, Executive Committee member and Fellow Robin Wilcox led a priority setting forum on the Healthy Pennsylvania 2010 Objectives. Another Executive Committee member and Fellow, Walter Tsou, Philadelphia's Commissioner of Public Health, presented on January 8, 2001, a talk entitled, *Rethinking Public Health in Philadelphia.* On April 2, 2001, in celebration of Public Health Week, the Section held a public health recognition night

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*Ed. note: Abstracts of the poster sessions are printed as the Appendix to the Transactions.

honoring Physicians for Social Responsibility for its contributions to the public health of our area. The final symposium of the year was held on June 5, 2001, co-sponsored with the College of Physicians of Philadelphia and offering a panel discussion on *Death on the Wing: Experts Evaluate the West Nile Virus.*

Again this year, the highlight was our pubic health poster session co-sponsored with the Pennsylvania Public Health Association and the New Jersey Public Health Association. This year's session, held on May 2, 2001, presented approximately 30 outstanding posters on public health issues.* The poster session winners were:

in the Open Category, *Local Health Department and School of Public Health Collaboration to Improve Public Health and Train Students.* Principal Presenter: Nathalie Bartle, Ed.D., MCP-Hahnemann.

in the Student Category, *Revising the Oral Contraceptive Patient Package Insert (PPI): Field Test and Evaluation.* Principal Presenter: Beth S. Ross, Temple University; and *Use of Perinatal Periods of Risk Model to Investigate Geographic Disparities in Philadelphia Infant Mortality.* Principal presenter: Kennen S. Gross, MCP-Hahnemann.

The Section's Executive Committee meets regularly in order to discuss public health issues and policies. The current membership of the Section approaches 200. The Section is pleased to report on an active 2000–2001 year and looks forward to an exciting and productive year under the leadership of Ann O'Sullivan, Chair, and Robin Wilcox, Clerk.

RICHARD J. COHEN, PH.D., F.A.C.H.E.
CHAIRMAN, SECTION ON PUBLIC HEALTH
AND PREVENTIVE MEDICINE

*Ed. note: Abstracts of the poster sessions are printed at the end of the Transactions.

Annual Report of the Section on Arts-Medicine

Perry Ottenberg, M.D., continued to chair the Section this year, assisted by Mary Anne Bartley, Vice-Chair; Paul Nolan, Treasurer; and members of the Executive Committee Burton Wasserman, Ph.D.; Rhonda L. Soricelli, M.D.; Kenneth Cundy, Ph.D.; and Rick Lippin, M.D. Gretchen Worden, Director of the Mütter Museum and College Gallery, served as CPP staff liaison.

The Section on Arts-Medicine programs for FY2001 were both related to the work of famous artists. The Philadelphia Museum of Art's exhibit *Van Gogh: Face to Face* provided the perfect opportunity to explore the relationship between Van Gogh's life and his portraits. On Wednesday, January 10, 2001, 40 members of the Section and their guests assembled in the West Lobby to hear Mary Ann Bartley give a special introductory presentation on *A Dialogue about the Life and Art of Vincent Van Gogh*. Bartley is vice-chairman of the Section's Executive Committee, as well as an artist-in-residence at Villanova University and artist/scholar at MCP-Hahnemann. She spoke of how Van Gogh's portraits have as much to do with how he felt about the subjects and himself as they do with the physical appearance of the subjects. Following her talk, the members toured the exhibit on their own and enjoyed the usual Wednesday night food and entertainment at the Art Museum.

On April 25, 2001, the Section on Arts-Medicine co-sponsored a College lecture with the Section on Medical History. The speaker was David Cast, Ph.D., Professor of History of Art at Bryn Mawr College. His subject was *The Anatomical Drawings of Leonardo da Vinci: Successes and Failures*. By examining two groups of Da Vinci's drawings, Dr. Cast showed how his work clearly changed following his exposure to dissections.

Upcoming programs for FY2002 will include artist Elizabeth Meyer on October 8, 2001, who will give a slide lecture on a personal traumatic event and how it affected and changed her artwork. In March, 2002, noted author and teacher Sandra L. Bertman, Ph.D., will talk about how to use all the arts—visual and literary—in helping patients and their families deal with death and dying.

Perry Ottenberg, M.D.
Chairman, Section on Arts-Medicine

Annual Report on External Affairs

Development

This has been a successful development cycle for the College. Our community service activities and other program initiatives continue to receive support from a diverse and growing number of government agencies, major foundations, small family trusts, and individual donors. During this period, the College also raised significant funds for building improvements. In a time of economic uncertainty and reduced charitable giving, the College continues to meet or exceed its goals in a very challenging environment.

Annual giving held steady, duplicating the $160,000 in unrestricted funds raised during the previous fiscal year. The number of donors (341) in FY01 was up (over 327 for FY00), but the average individual contribution ($464) was below the FY00 average ($493).

The College received $200,000 from the federal Centers for Disease Control and Prevention (CDC) in FY01, the first year of a three-year grant for the C. Everett Koop Community Health Information Center. The purpose of the grant is to implement the College's partnership with the Free Library of Philadelphia and to prepare for the Center's expansion. In March 2001, the CDC invited the College to submit a proposal for a non-competitive renewal for year two of the grant. The College anticipates an additional $200,000 from CDC in the coming fiscal year. A second key initiative is to expand the College's museum-based education program. The College has applied for a second, two-year grant, from the federal Fund for the Improvement of Education (FIE) in support of this activity. The College is exploring other sources of funding to expand its educational outreach to students in the School District of Philadelphia.

The College received the first $500,000 installment of the Benjamin and Mary Siddons Measey Foundation's pledge of $1.9 million in support of the William Maul Measey Chair in Medical History at the College. William Maul Measey, a distinguished corporate attorney in Philadelphia, created the Foundation in 1958 to honor the memory of his parents. Edward Morman, M.S.L.S., Ph.D., new Col-

lege Librarian and Director of the Francis C. Wood Institute for the History of Medicine, inaugurated this chair at the College. In March 2001, the College submitted a three-year grant for $575,000 to the William Penn Foundation to support conservation, cataloguing, preservation and dissemination activities in the Historical Library. Indicators are positive for a favorable decision on this request.

The College received over $100,000 from the Barra Foundation and the Groff Family Memorial Trust to acquire new automated cataloging systems for the College Library and the Mütter Museum. The *Argus Museum Cataloging System* includes a catalog database with an image management system and a web access module, to make the catalog accessible to researchers through the Internet and links to the Historical Library's online catalog. The advanced technology of the Endeavor *Voyager* system enables the Historical Library to have better administrative control over its collections, increase information accessibility to its patrons, and streamline workflow to provide faster and more efficient processing of materials.

Providing appropriate care for the College's priceless library, museum, and fine arts collections is of limited value unless the College also provides prudent stewardship of the building that houses them. Grant support for capital improvements is the most difficult support to secure. However, during this period, with funding of $906,000 from the federal Health Resources and Services Administration (HRSA), $45,000 from the Pennsylvania Historic and Museum Commission, and building fund contributions from the Fellowship, the College launched a major historic building renovation project. An independent, but related project was the restoration of Mitchell Hall to its former status as one of the grand meeting halls of Philadelphia. This renovation project was made possible in part through a $60,000 gift from the McLean Contributionship, $30,000 from the Arcadia Foundation and contributions totaling over $70,000 from College Fellows and the Women's Committee. In 1999, a lead grant from the McLean Contributionship, and subsequent contributions from its Fellows and friends, enabled the College to restore the three façade leaded-glass windows in Mitchell Hall. The recent renovations brought closure to what has been termed the *Mitchell Hall Millennial Restoration Project*.

EDWARD F. PLOCHA
DIRECTOR OF DEVELOPMENT
AND EXTERNAL AFFAIRS

Public Relations

Public relations activities during this reporting period included a mix of special projects, as well as ongoing promotion of College programs and services. Highlights of the past fiscal year appear below.

A. American Medical News *Series*

Bonnie Booth, editor of the Professional Issues Section of the *American Medical News* invited the College to write a regular monthly column on medical history for the magazine. This provided continuing opportunities for the College to focus on and promote items from its own library, museum, and fine arts collections in producing this column. To date, this series has included pieces about a medicine chest belonging to the American medical pioneer and College co-founder, Dr. Benjamin Rush; the original handwritten constitution of the American Medical Association, which was donated to the College; and the College's Historical Medical Digital Library. The opportunity for the College to have such a column stems from an in-depth feature on the College Ms. Booth published during the last reporting period.

B. Meeting with The Inquirer *Editorial Board*

Seeking an appropriate conclusion to the College's work on presidential disability and the 25th Amendment, Dr. William L. Kissick, Chair of the College's Task Force on Presidential Health and Executive Director Dr. Marc Micozzi met with Chris Satullo, editor of the *Philadelphia Inquirer*'s editorial page and the other members of the editorial board. During the discussion that followed the College's presentation, Dr. Kissick noted that, unlike members of the cabinet, the U.S. Surgeon General has a statutory appointment and cannot be fired by the president. This is important because the 25th Amendment provides that, in certain circumstances, cabinet members can help to determine whether a president who is seriously ill should remain in office. Following this meeting, the College was invited to submit an op-ed piece on presidential health to the *Inquirer*. Dr. Kissick and Dr. Micozzi co-authored the piece submitted to the paper.

C. WHYY-TV Program Breaks Promote the College

Philadelphia's local PBS station, WHYY-TV, Channel 12, began the new year by introducing the station's prime-time schedule with

pre-taped segments shot at the College. Channel 12 personality Ed Cunningham made timely connections between the College's Library, Mütter Museum, and Koop Community Health Information Center and the programs airing on the station. For example, the broadcast of "Washington Week in Review" was preceded by a taped segment in which Mr. Cunningham discussed the College's exhibit on presidential health. During these taped segments he repeatedly praised the College's collections and invited viewers to plan a visit to the College in the near future. These segments aired over a period of ten nights. The station reaches approximately 50,000 households in the Delaware Valley each week.

D. College Leaders Meet With Senator Specter

On June 26, 2001, College President Dr. Allen R. Myers and Executive Director Dr. Marc S. Micozzi met in Washington with U.S. Senator Arlen Specter (R- Pennsylvania). The purpose of the meeting was to confer an Honorary Fellowship on the Senator in recognition of his leadership on such issues as significantly increasing federal support for medical research, advocating fair reimbursement formulas for Pennsylvania hospitals, and helping to protect academic medical centers against reductions in federal support, which could cripple their effectiveness. The Senator made time for this meeting in the midst of the debate on the Patient's Bill of Rights, meeting with College officials in an anteroom off the Senate floor. This meeting was coordinated by the Director of Public Relations.

E. Profiles of Dr. Myers

As the simultaneous President of the College of Physicians of Philadelphia, President of the Greater Philadelphia Healthcare Congress, and former Dean of the Temple University School of Medicine, Dr. Myers is seen as a leader in the region's healthcare community. During this reporting period, Dr. Myers was profiled by the *Philadelphia Business Journal* and *Physician's News Digest*. Both articles provided Dr. Myers with useful opportunities to emphasize the College's commitment to public service as well as the College's distinguished history.

F. CDC Director Speaks at College

In March 2001, Dr. Jeffrey Koplan, Director of the U.S. Centers for Disease Control and Prevention discussed the global challenges in-

volved in preventing and containing infectious diseases. Speaking to an audience of Delaware Valley public health leaders, Dr. Koplan noted that from a health perspective, national borders are now essentially meaningless. He also noted that while it took almost 400 days for a ship to go around the world in 1850, today airplane passengers can accomplish the same mission in 36 hours. As reporter Huntly Collins noted in her *Inquirer* story on Dr. Koplan's visit, richer diets and lifestyle patterns associated with the West are poised to do great damage in the developing world. Collins quoted the statistic that while 60 percent of Chinese men smoke, half of this population is unaware of the health risks associated with this habit.

Media Coverage 2001–2002

Television Features that Repeat Regularly (Now Showing)

Discovery Channel: Hour-long documentary on the Mütter Museum.

Travel Channel: "World's Most Unusual Destinations" and "World's Most Curious Destinations." Both include interviews with Marc Micozzi and Gretchen Worden.

PBS: A feature on interesting places to visit in Philadelphia, including the Mütter Museum; hosted by Burt Wolf; airs repeatedly.

Bravo Channel: "First Person" series produced by Errol Morris; interview with Gretchen Worden. Rebroadcast numerous times on the Bravo Channel and on Channel Four in the UK, September 6, 2001.

History Channel: "History's Lost & Found." An interview with Marc Micozzi on President Grover Cleveland's secret operation; interview with Gretchen Worden on Chang and Eng, the original Siamese twins (rebroadcast as two separate shows).

Features to be Broadcast in 2002 (Airdates to be Determined)

C-SPAN: Interview with Marc Micozzi on presidential health; interview with Gretchen Worden on the Mütter Museum and its collections; to be used as filler spots between regular programs; projected air date Spring 2002.

National Geographic Channel: "The Mummy Road Show" hosted by radiographer Jerry Conlogue and endoscopist Ron Beckett of Connecticut's Quinnipiac College, Connecticut; features scan of Soap Lady.

Travel Channel: "Curious World." Feature on research use of Mütter Museum collections; interviews with docent Mrs. Adele Bedrossian, radiologist Dr. Morrie Kricun, and Gretchen Worden.

Discovery/BBC: Documentary "Medical Mysteries." Discusses human growth disorders including gigantism and features giant skeleton; interviews with Marc Micozzi and Gretchen Worden.

Other Television Coverage During 2001

November 8, 2001: **The Learning Channel**: "A Dating Story." A young couple spends their first date at the Mütter Museum.

August 22, 2001: **MSNBC**: Feature on Conjoined Twins.

June 4, 2001: **Celera Genomics Online**: Features Harry Eastlack's skeleton for a discussion on Fibrodysplasia Ossificans.

February 9, 2001: **Channel 5 (UK)**: Documentary on Conjoined Twins.

January 7, 2001: **Reuters Health Video Online**: Fibrodysplasia Ossificans.

Print Media Coverage During 2001

Philadelphia Inquirer
"College of Physicians Is Back on Road to Health"
November 16, 2001

New York Times
"When Bioterror First Struck the U.S. Capital"
November 6, 2001

Philadelphia Inquirer
"Diseases Make World Seem Small"
March 19, 2001 (Dr. Koplan, Director of the Centers for Disease Control, spoke at the College on March 15, 2001)

Physician's News Digest
"College of Physicians Balances Change with Tradition"
January, 2001

Philadelphia Business Journal
"College of Physicians Aims for Higher Profile"
January 12, 2001

American Medical News

"The Story Behind a Portrait at the College of Physicians of Philadelphia"
By Luther W. Brady, Jr., M.D.
December 24, 2001

"Mysterious Disease Overwhelms Medical System (in 1793)"
By Dick Levinson
October 22, 2001

"Exhibit Explores 19th Century Ideas About Criminals"
By Dick Levinson
September 24, 2001

"Digital Library Lets You Virtually Pull Books Off the Shelf"
By Charles Greifenstein
August 27, 2001

"Manuscripts Yield Tales of Hissing and Bloodletting"
By Charles Greifenstein
July 30, 2001

"A Look Inside Dr. Benjamin Rush's Medicine Chest"
By Gretchen Worden
June 25, 2001

Richard Levinson
Director of Public Relations

Annual Report of the Katherine A. Shaw Division of Public Services

The Katherine A. Shaw Division of Public Services includes the C. Everett Koop Community Health Information Center, College Gallery, Mütter Museum, Reception Desk and Gift Store, and Information Systems.

The C. Everett Koop Community Health Information Center (CHIC)

The College staff continued to implement the recommendations made in the Centers for Disease Control (CDC) evaluation of the CHIC as a physician-based model for the dissemination of health information. A three-year implementation plan was developed and is now underway. By the end of the grant period in 2003, the CHIC will accomplish the following:

- Establish CHIC visibility among librarians and other key audiences by ensuring that 25% would mention the CHIC as a consumer referral source.
- Establish CHIC as a Web-based resource by building links to 200+ key sites.
- Increase CHIC acceptance among College Fellows by ensuring that 75% will indicate the CHIC as a valuable resource that adds value to the College mission.
- Increase CHIC patronage by 25% over baseline (FY2000) patronage.
- Encourage adoption of CHIC model by 25% of relevant institutions.

Underlying these objectives are two "streams" of tasks that will:

- Increase the visibility and patronage of the CHIC in its primary service area (Philadelphia).

- Document the CHIC program and publicize it as a national model.

Access

In an effort to best meet the public's health information needs, the CHIC continues to offer expanded hours of service: Tuesday through Saturday, 10 A.M.–4 P.M. The CHIC has continued to monitor the effectiveness of this schedule by keeping an attendance log. In addition, the CHIC continues to publicize these expanded hours in its promotional materials. To encourage access to CHIC resources the College has eliminated its fee for borrowing CHIC materials and offers individuals free CHIC membership to borrow books and audiovisuals. The CHIC currently has 123 registered borrowers. The CHIC also has made its resources available at no cost to the general public through interlibrary loan via the Free Library of Philadelphia.

The CHIC doubled its attendance from last year with a total of 4,099 visitors. Listed below is the monthly CHIC visitor counts from July 2000 through June 2001:

July	384	November	399	March	412
August	370	December	163	April	400
September	277	January	227	May	490
October	306	February	331	June	340

Below are the monthly CHIC visitor counts from July 1999 through June 2000 for comparison:

July	94	November	76	March	250
August	64	December	224	April	308
September	57	January	162	May	313
October	46	February	240	June	182

Enhanced Resources

The CHIC continued to acquire consumer-oriented health information, including books, videos, and free brochures and pamphlets. The most popular resources are the free health information brochures, leaflets, and pamphlets. Nearly 12,000 pamphlets were disseminated to the public during FY2001. The most popular brochures are as follows:

Allergies
Am I Parent Material?
Aspirin and Your Health
Asthma
Benefits and Rights for Older Pennsylvanians
Breast Cancer—Treatment Guidelines for Patients
Chlamydia
Depression
Drugs Facts
Now You Have a Diagnosis, What's Next?
Tips for Teens about Smoking
Understanding and Controlling Cholesterol
Understanding Prostate Changes
Understanding Stroke
Violence in the Family

The CHIC continues to include in its collection materials for low-literate and non-English-speaking audiences. When selecting materials for the collection, the CHIC maintains a patron-centered perspective by addressing the needs of diverse characteristics such as age, education, gender, ethnicity, cultural beliefs, and primary language.

Outreach Activities

Increased CHIC visibility and community involvement are being achieved by developing relationships with other community organizations that can serve as referral agents to the CHIC. The College is also investigating organizations to serve as dissemination points for quality health information such as physicians, libraries, community-based organizations, and local, state, and national governmental agencies. The College staff is also interested in disseminating information about the CHIC and its services. College staff was involved in the following activities:

- Director of Public Services, Andrea Kenyon, attended a symposium on March 12, 2001, entitled *A.R.C.H.E.S. Gateway to Community Health*, sponsored by the Jefferson Health System, in order to learn about their community health programs and determine ways that the CHIC can complement these activities. CHIC staff will set up meetings with the Jefferson Health System's Regional Director of Community Health and the Manager of their Chinese Health Information Center in May 2001 to discuss opportunities for collaboration.
- Executive Director Marc S. Micozzi offered testimony on the CHIC as an innovative, credible approach to consumer

health education and health promotion before the White House Commission on Complementary and Alternative Medicine Policy Panel on Children, Families and Communities, on March 26 and 27, 2001.

- On April 11, 2001, Andrea Kenyon was invited to the University of Pennsylvania Health System's Council on Health Promotion and Disease Prevention to give a presentation about the CHIC. This proved to be an excellent opportunity to inform the academic medical community about CHIC resources and services.
- Dr. Marc Micozzi and Andrea Kenyon met on April 19, 2001, with Bruce Riegel, Division Director, Philadelphia Field Office, Health Resources and Services Administration, and Natalie Levkovich, Director of the Health Federation of Philadelphia, at the recommendation of Dr. Donald Weaver, Director, National Health Service Corps/BPHC/HRSA, to discuss ways that the College can contribute to the BPHC campaign for 100 percent access and zero health disparities. In addition there was discussion on ways that the CHIC could support staff and patient health information needs at Philadelphia's federally qualified health clinics.
- On May 30, 2001, Andrea Kenyon gave a presentation about the CHIC/Free Library of Philadelphia partnership at the 2001 Medical Library Association's Annual Meeting Symposium entitled *Library Partnerships: Making Powerful Connections* in Orlando, Florida.

Free Library of Philadelphia

The College continued to develop its partnership with the Free Library of Philadelphia. Numerous meetings were held to discuss the direction and scope of the partnership. The Core Team of College and Free Library Staff was created to plan and implement a program that would address the health information needs of the public and ensure city-wide access to quality health information throughout the city utilizing the Free Library system and the CHIC. The Core Team includes representatives from the public library system, including the Business, Science, and Industry Departments. The following subcommittees were created to address specific areas for potential collaboration: Referral and Interlibrary Loan, Training, Website Development, and Promotion. The Core Team advises the College on

ways to make the CHIC more accessible to the public and make recommendations as to how public library staff can benefit from the expertise of the CHIC and its staff. The Core Team has met regularly to discuss possible ways to collaborate. Initial areas of cooperation include developing a health reference triage and referral plan, exploring possible resource sharing, providing health information workshops for public library staff and patrons, and expanding health information on the CHIC and public library websites.

Providing Internet training for the public has placed additional demands on the already busy public library staff. It was determined that the CHIC would work with the public library to assist in developing and implementing health information workshops for patrons. Two collaborative general health information workshops were offered in June. Health information workshops targeting senior citizens are currently being developed and will be offered in July 2001. This decision is based on studies that cite the growing use of the Internet by Americans over age 50. The incidence of chronic diseases in older adults makes it important that older adults and caregivers get access to credible information about prevention and early treatment. CHIC and public library staff persons attended the Spry Foundation's second biennial national conference entitled *Older Adults, Health Information, and the World Wide Web,* on February 26–28, 2001, in order to enhance their knowledge of skills for developing a health information workshop for senior citizens.

The creation of a web-based health information tutorial for public librarians is also in the planning stage. CHIC staff person Eric Darley attended *Designing and Implementing Web-based Training*, an interactive online workshop taught by internationally recognized training consultant Diane Kovacs on April 2 and 9, 2001. The workshop provided practical guidelines and a vital theoretical framework for creating such web-based tutorials.

CHIC staff provided Free Library staff with a workshop on how to find and evaluate health information, which was offered June 26, 2001, at the College of Physicians of Philadelphia. Twenty-one Free Library staff persons attended this workshop, which provided them with the opportunity to visit the CHIC and learn more about the services and resources available.

CHIC and public library staff attended the first *Public Library and Consumer Health Conference*, sponsored by the Public Library Association, Medical Library Association, and the National Library of Medicine on January 10–11, 2001. The conference provided an overview of the evolution of consumer health information

services. Dr. Thomas Ferguson, the keynote speaker, focused his remarks on self-care and the current and potential use of the Internet by consumers and health care professionals. A panel presentation featured participants in the NLM/Public Library Partnership pilot projects who discussed their consumer health initiatives. CHIC and public library staff attended the following workshops: *Planning and Managing the Consumer Health Library* and *Consumer Health on the Internet*. The conference provided CHIC and public library representatives with an opportunity to share information about what they were doing to meet consumer health information demands in the Philadelphia area, meet new colleagues, and to exchange ideas.

Visibility and Awareness Effort with Physicians

The College completed its survey of College Fellows practicing in Philadelphia for their input regarding how the CHIC could best serve them in responding to their patients' health information needs. A survey form and information about the CHIC's resources and services were sent to 509 College members. A total of 170 surveys were returned. CHIC brochure holders were sent to 60 College Fellows for placement in their waiting rooms. CHIC staff plans on following up with these physicians to get feedback on the brochure holders and to identify additional ways the CHIC can support patient education.

Public Schools

The College continued its efforts to integrate the information resources of the CHIC with the educational opportunities of the Museum and Gallery. The School for Health: Physicians Working Toward a Healthier Community Program incorporated a visit to the CHIC as part of its museum field trip experience. CHIC health collections for schoolchildren in grades K–12 have been expanded and complement the College's museum-based health curriculum developed for the Philadelphia School District. Promotion of the CHIC and its resources has been incorporated into both the genetics and infectious disease student and teacher workbooks. Emphasis is being placed on nutrition, substance abuse, infectious diseases, anatomy, health awareness, and prevention.

Promotion

New CHIC signage was developed to help identify resources and services and improve the appearance of the CHIC. A new CHIC brochure was developed and distributed to Free Library of Philadelphia Main and Branch Libraries, as well as to other libraries, doctors' offices, and health agencies in the city. A poster promoting the CHIC is also being developed. During the month of March the local educational public broadcasting station, WHYY, hosted public service spots featuring the CHIC during program breaks. Additional joint promotional efforts between the Free Library of Philadelphia and the CHIC are being explored, including a joint brochure and poster.

Andrea L. Kenyon, M.L.S.
Director, Katherine A. Shaw Division of Public Services

Annual Report of the Mütter Museum and College Gallery

Visitors and Income

The total number of visitors to the Museum and Gallery in FY2001 was 30,515, an increase of 7,790 over FY2000. The increase may have been partly due to the expanded public hours. In March 2000, Sunday hours from 12–4 were added, and in May 2001 the hours were changed to 10–5, seven days a week. It is difficult to arrive at an exact comparison of attendance figures for various years because of the changes in the number of days and hours that the Museum has been open from year to year. Between FY90 and FY96, the Museum was open Tuesday through Friday, and the average daily attendance increased from 25 to 89.9. Admission charges also changed, from free admission through FY94, to a $2 charge in FY95. In June 1996 the Museum hours became 10–4 Monday through Saturday, and in FY97 average daily attendance was 78.3. Admission fees became $5 in June 1996 and $8 in October 1996. In FY98 and FY99, public hours were reduced to five days a week, eliminating Mondays, and the average daily attendance dropped to 73.1. In FY2000 the public hours went from five days a week for the first three months, six days a week for the next six months, and seven days a week for the last three months. During that period average daily attendance went from 85.4 to 46. However, in FY2001, with the Museum open seven days a week and no change in the admission fee, average daily attendance reached 83.8. There is every reason to believe that the upward trend of both total number of visitors and average daily attendance will continue to increase, both because of increased accessibility and publicity.

The demographics of visitors are also interesting. In FY2001, 9,503 visitors paid the individual student rate admission, or 31% of the total number of visitors, and 5,727 came as part of a student group tour, or 18% of the total. Together, student visitors, which include children from ages 6 to 18 and college students, accounted for almost 50% of the total number of visitors to the Museum. While

resulting in lower revenues ($5 versus $8 adult admissions), it is gratifying to see that the Museum has such a strong appeal to the younger generation.

Total admissions income for FY2001 was $185,692, an increase of $61,667 over the previous fiscal year.

Reception Desk Staffing

Weekday receptionist Stephanie Hicks left the College in May 2001. She was replaced by Laura Johnson in July 2001. Weekends were staffed by Melissa Clemmer, who was succeeded by Barbara Saba in March 2001. Both were students who found it difficult to continue because of the demands of their studies. Camille Lewis became the regular weekend receptionist in April 2001. Interim coverage of the reception desk continues to be provided by other College staff, including Paul Reilly, Sofie Sereda, and Margaret Lyman.

College Gallery Exhibit

Emerging Infectious Diseases: Ancient Scourge and Modern Menace continued on exhibit in the Gallery. It will be reinstalled in the Museum in a smaller version in January of 2003, to make way for the next exhibit in that space, *Only One Man Died: The Medical Aspects of the Lewis and Clark Expedition*. Planning is already well under way for the new exhibit, which will represent the College's contribution to the local commemoration of the 1803–1806 Lewis and Clark Expedition.

FIE Grant for Education Program

A total of nine classes from Martin Luther King High School, Simon Gratz High School, Cook Middle School, and Vare Elementary School participated this past year in the Museum's education program supported by the federal Fund for Improvement of Education grant. The students came to the College for a special lesson provided by the Museum Educator, Gloria Shaner, plus a tour of the College Gallery and Museum. All of the students and teachers received the

workbooks on genetics designed by Mrs. Shaner, which prepared them for their visit and also provided follow-up lessons. The workbook on infectious diseases is in progress and will be completed in the fall of 2001.

Thomas Dent Mütter Lecture

Raymond J. Carr, a Special Agent for the Federal Bureau of Investigation, presented the annual Mütter Lecture for FY2001 on December 7, 2000. His subject was *The Crime Scene Story*. A specialist in analyzing violent crimes, Mr. Carr discussed the ways in which investigators can learn about the nature of the offender by examining crime scenes for manifestations of behavior patterns.

Mütter Museum Calendar 2001

The 2001 Mütter Calendar was sold in bookstores in the United States and Great Britain. It included several photographs by noted photographer William Wegman, featuring his famous Weimaraner dogs in the Museum, as well as the work of new contributors, Harvey Stein of New York and Richard Ross of California.

Photographs from the current and previous calendars were featured in an exhibit at the Barrister's Gallery in New Orleans, Louisiana, in December 2000. The Director was invited to give a slide presentation at the opening of the exhibit.

Objects Received

The following items were received at the Museum for possible accession:

- Medical equipment and supplies from the office of Dr. Robert H. Dreher, offered by Robert J. Dreher, executor.
- Set of Civil War period ivory-handled surgical instruments, and ENT specialist's chair; a bronze plaque of Hippocrates; and a leather doctor's bag formerly belonging to Dr. G.M. Farnsworth, offered by Stanley Kelley, D.O.

- Ultraviolet goggles and a Birmingham nasal douche, offered by Dena Dannenberg.
- Trial lens case and Haag-Stret slit lamp, offered by Myron Yanoff, M.D.
- Assorted digital hearing aids, offered by Joel Mynders, President, A.P. Mynders & Associates.
- Examining table designed by Dr. Isidor Ravdin and used at the University of Pennsylvania from the late 1940s to the present, and a biliary duct drainage board, offered by the John Rhea Barton Surgical Associates, University of Pennsylvania Health System.
- Dr. Ravdin's parking plate and a Ravdin needle in original packaging, offered by the Department of Surgery, University of Pennsylvania Medical Center.
- Framed portrait of Dr. Robert H. Bradley, Jr., by Emilie R. Bregy, offered by Robert H. Bradley, Jr., M.D.
- Medals awarded to Dr. Stanley P. Reimann, including the I.P. Strittmatter Award of the Philadelphia County Medical Society, 1956, offered by Mrs. Elizabeth R. Bodine.

Museum Loans

The Museum lent photographs and objects relating to giants and conjoined twins to the Woodmere Art Museum in Chestnut Hill for an exhibit of the work of artist James Mundie. A skull of a murderer and an anthropometric device were sent to the University Art Museum of the University of Albany, New York, for an exhibit on forensic anthropology. Dr. Fred Kaplan of the University of Pennsylvania School of Medicine again made arrangements to transport the skeleton and photographs of FOP victim Harry Eastlack to the Franklin Plaza Hotel for the Third International Symposium on Fibrodysplasia Ossificans Progressiva. Two eighteenth-century anatomical prints of the brain by Jacques Fabien Gautier-Dagoty were lent to the National Academy of Sciences in Washington, D.C., for a special exhibit on the brain. An Auzoux papier-mâché model of the larynx was lent to the American Philosophical Society for an exhibit on scientific instruments. Surgical instruments and obstetrical and gynecological instruments were lent to the Pennsylvania Hospital for a special exhibit in celebration of their 250th anniversary.

Staff Activities

Director Gretchen Worden attended the annual meeting of the National Museum of Civil War Medicine in Frederick, Maryland; the biannual meeting of the European Association of Museums of the History of Medical Sciences in Oporto, Portugal; the annual meeting of the Society of Civil War Surgeons in Chattanooga, Tennessee; and the annual meetings of the Medical Museum Association and the American Association of the History of Medicine in Charleston, South Carolina. Collections Manager Margaret Lyman attended the meeting of the Mid-Atlantic Association of Museums in Baltimore, Maryland, and a training session for the use of the Argus collections management system in Pasadena, California.

The Director gave presentations on the Mütter Museum at the South Jersey Hospital; the University of Virginia School of Medicine in Charlottesville, Virginia; the Wangensteen Library of the University of Minnesota School of Medicine in Minneapolis; the Independent School Art Instructors meeting in New York, the University of the Arts Museum Exhibition Design program, and the Mid-Atlantic Regional Archives Conference in Philadelphia; and the Crosslands Retirement Community in Kennett Square, Pennsylvania.

Director of Education Gloria Shaner attended the American Association of Museums annual meeting in St. Louis, Missouri, where she exhibited information about the FIE-funded museum education program.

Publicity

Publicity this year focused on the Museum as one of Philadelphia's must-see tourist attractions, and also on our conjoined twins and fibrodysplasia ossificans progressiva exhibits. The Republican National Convention in August 2000 resulted in numerous articles about the places delegates should visit while in Philadelphia, and in that context the Museum was mentioned in *TIME*, *Newsweek*, *USA Today*, the *Philadelphia Inquirer*, and the *Philadelphia Daily News*, as well as in the convention-related publications from the Associated Press, the Philadelphia Convention and Visitors' Bureau, the Greater Philadelphia Tourism and Marketing Corporation, and the Philadelphia Office of Arts and Culture. A traveling version of

the presidential health exhibit was installed at the Philadelphia Convention Center as part of the special RNC PoliticalFest event.

Travel articles featuring the Museum appeared in the *American Way* magazine of American Airlines, the *Wilmington News-Journal*, the *Chester County Press*, the *Philadelphia Inquirer*'s annual student guide, *Index* magazine, *Men's Health* magazine, *Comcast Online*, and the American Academy of Neurology's newsletter. The *Times-Picayune* published a review of the December Mütter Museum calendar exhibit in New Orleans.

Online video stories on FOP featuring the skeleton of Harry Eastlack appeared on the *Reuters Health Video Online* program, *Comcast Online*, the CNN website, and Celera *Genomics Online*. The Associated Press and *Metro*, a local daily newspaper, published articles on Harry Eastlack and FOP in connection with the FOP Symposium.

Our conjoined twins collections were featured in a Channel 5 UK documentary, a program on MSNBC, and in a program for the Seoul Broadcasting System. The Travel Channel filmed an interview with Executive Director Dr. Marc S. Micozzi and Museum Director Gretchen Worden for a feature on *The World's Creepiest Destinations*. Local TV channels 10 and 29 interviewed Dr. Micozzi on the subject of the presidential health exhibit, and the New Zealand Natural History Health Series for the Discovery Channel filmed an interview with Dr. Tony Tizzano in the Museum on the subject of obstetrical instruments, including several from the Museum's collection.

Dr. Micozzi and Gretchen Worden were also interviewed for a BBC documentary on gigantism and other growth disorders, including Marfan's Syndrome, and the Museum's giant skeleton was featured in the piece. The Travel Channel also filmed the Museum for a *Curious World* segment, showing how the collections are used for education and research. Both of those programs have not yet aired.

The Mütter Museum was also included in a book by Elizabeth S. Gephart on *Philadelphia With Children,* and in a book by Stephen T. Asma, *Drama in the Diorama*, about the culture and evolution of natural history museums.

GRETCHEN WORDEN
DIRECTOR, MÜTTER MUSEUM

Annual Report of the Historical Library

During 2000–2001, the Historical Library experienced several important transitions. Staff and contractors accomplished much in preservation, cataloging, and digitization of the collection; major changes were made in Library staffing; and the Library adopted new software for its online catalog.

Grant-Supported Work and Other Special Projects

During this year the Library applied for and was granted a four-month no-cost extension to its National Leadership Grant from the federal Institute for Museum and Library Services (IMLS). By the end of June, then, all work supported by the grant was completed. This included:

1. Conservation of the eight thousand items in the Sturgis Print and Photograph Collection.
2. Placement of 1,500 fragile books, printed between 1501 and 1900, in specially produced acid-free cardboard "phase boxes."
3. Placement of fifty books printed before 1500 in sturdy "clamshell" boxes.
4. Completion of the first phase of the Historical Medical Digital Library, which encompasses scanned images of fifty of the books preserved with grant funds, including complete scanning of two books. Scanned images are linked to records in the Library's online catalog.
5. Creation of 126 online records for manuscript collections held by the Library.

With the momentum provided by the IMLS grant, Library staff—assisted by the College's Executive and Development Offices—prepared a proposal to the William Penn Foundation for continuation and expansion of this work. In July 2001, the College learned that the Library had won $638,000 for the following projects:

1. Creation of phase and clamshell boxes for preservation of more than two thousand additional early printed books.

2. Creation of high-quality electronic catalog records for one hundred books printed before 1501, as well as several hundred sixteenth-century books.
3. A complete retrospective conversion of all card catalog entries for periodicals into electronic catalog records.
4. A conservation survey of the library's nineteenth- and twentieth-century collections.
5. A thorough cleaning of the library stacks and the materials they hold.

During 2000–2001, contractors also finished work on a new HVAC system for the Library stacks, funded largely by a grant of almost a million dollars from the federal Health Resources and Services Administration. Cleaning the stacks and vacuuming the books and manuscripts will complete the job of providing proper ambient conditions for storage of library materials.

A smaller grant from the Children's Hospital of Pennsylvania supported completing the cataloging of the Samuel X Radbill Pediatric Historical Library. Non-grant-funded special projects included rearranging and recataloging portions of the historical reference collection. The Library also applied to the Pennsylvania Historical and Museum Commission for funds to hire a temporary employee who would process the papers of former Library Directors Walton B. McDaniel and Elliott Morse. The grant was awarded, and work on this project began in May 2001.

The current round of environmental, preservation, digitization, and cataloging projects will help the Library maintain its status as one of the world's premier medical historical collections. The College is now in the forefront of major medical historical libraries in terms of maintenance and access to its magnificent collections.

Staff Changes

Toward the end of the summer of 2000, Marjorie Smink announced her resignation as Library Director. Ms. Smink had been with the Library since 1980, serving as director for the previous three years. Intelligent, hard working, and dedicated, Ms. Smink helped the Library survive some difficult years of austerity, staff cutbacks, and change of mission. The College salutes her and wishes her well in her new position. She remains a valued member of the Library Advisory Committee.

Between Ms. Smink's resignation and her final day as a College staff member, Dr. Edward T. Morman accepted the position of Director of the Francis C. Wood Institute for the History of Medicine. College governance, College administration, and Dr. Morman agreed that it would be wise for Dr. Morman—an experienced medical history librarian—to serve also as College Librarian. For more on Dr. Morman's appointment and qualifications see the Wood Institute annual report, below.

During the period between Ms. Smink's departure and Dr. Morman's arrival in July 2001, Curator of Archives and Manuscripts Charles Greifenstein served as Interim Library Director. In this position he played a leading role in preparing the application to the William Penn Foundation, and in administering the IMLS grant. He also managed day-to-day operations of the Library, and served as staff liaison to the Library Advisory Committee and the Section on Medical History.

On March 1, Laura Guelle, who had been cataloging the Radbill Collection, became Rare Book Librarian/Cataloguer.

New Catalog Software

Implementing a decision made the previous year—and reflecting the Library's new mission as a medical *history* library—in 2000–2001 the Library ceased participating in the joint catalog of the Philadelphia Health Science Library Consortium. The catalog database was transferred to a server maintained by Endeavor Information Systems, Inc. in Chicago, and the catalog itself maintained using Endeavor's Voyager software (the same software used by the University of Pennsylvania and the University of the Sciences in Philadelphia). Library staff customized the Voyager catalog during the summer of 2001. The Library adopted the name *CPPSource* for the online catalog, on the suggestion of Levi Carroll of the College Hall and Grounds staff.

Archival Discovery

In the process of moving furniture for the building renovation project, Facilities Foreman Leroy Green encountered two bundles of documents. Charles Greifenstein inspected and inventoried these papers (apparently not seen since being moved into the College's current

home in 1909), and transcribed several of them. They include dozens of letters and reports from the 1790s, many of which deal with the infamous yellow fever epidemic of 1793. Other items are reports of the College's meteorological committee in the 1840s, and the draft of John Shaw Billings's speech given at the opening of the Johns Hopkins Hospital in 1889. These will all be processed and will constitute a valuable addition to the College's manuscript collections. A more detailed report on this discovery appears in the From the Archives section, later in this volume.

Manuscript Acquisitions

Charles Greifenstein, Curator, Archives and Manuscripts, reports the following additions to the manuscript collections:

- Papers, reprints, and books of Arthur Vincent Meigs (1850–1912), CPP President. Donated by his great-granddaughter, Anne Meigs-Brown. Total: 1.6 linear feet. July 18, 2000.
- Correspondence, photographs and other documents of Edward O. Shakespeare (1846–1900), CPP Fellow. Donated by his grandson, E. O. Shakespeare. Total: 5.0 linear feet

As the official repository of the archives of the American Association for the History of Medicine, the College Library also received 1.4 linear feet of recent files from Todd Savitt, Secretary-Treasurer of the AAHM.

Reference

Christopher Stanwood, Reference Lbrarian, reports that the Library serviced 299 readers during 2000–01. Of these, 24 percent were graduate students, 19 percent were Fellows of the College, 11 percent were other physicians, and 8 percent were academic historians. Other categories of readers included writers, genealogists, undergraduates, legal researchers, and medical students.

Staff paged 554 rare books, pamphlets, and journals, 1,355 19th-century items, and 2,617 20th-century items. Five hundred seventy-four items were retrieved from the manuscript collections.

Staff responded to 204 telephone inquiries, and 340 inquiries by mail or e-mail. Twenty items were circulated to fellows, four to staff. 1,280 interlibrary loan requests from other institutions were filled.

Technical Processing

The Library is now devoting more funds to the purchase of scholarly books in history of medicine and related fields. Coordinator of Technical Services Joan McKenzie reports that 303 books were received and 238 new titles cataloged in 2000–01. Serial subscriptions declined to one hundred.

Charles Greifenstein, M.S., M.A.
Interim Library Director

Annual Report of the Francis C. Wood Institute for the History of Medicine

In the absence of a director, Marjorie Smink, Charles Greifenstein, and Sofie Sereda of the Historical Library staff continued to administer the Francis C. Wood Institute for the History of Medicine during 2000–2001. The Institute's activities included the Wood Fellowship program, and the 2000 number of *Transactions and Studies of the College of Physicians of Philadelphia*. Deborah Franklin, M.D., Ph.D., worked with Library/Wood Institute staff as editor of *T&S*.

In September 2000, the College announced that Edward T. Morman, M.S.L.S, Ph.D., would start on July 1, 2001, as College Librarian and Director of the Wood Institute, occupying the Measey Chair in the History of Medicine. The Benjamin and Mary Siddons Measey Foundation had recently endowed the Measey Chair within the Wood Institute, as part of its effort to bring more history to the curriculum of Philadelphia area medical schools. Dr. Morman's responsibilities will therefore include the Historical Library; traditional Wood Institute programs (fellowships, seminars, conferences, etc.); and outreach to the medical community, medical educators, and other scholars and students.

Dr. Morman arrived at the College of Physicians following four years as Associate Academy Librarian for Collections and Historical Programs at the New York Academy of Medicine, where he successfully revived that institution's medical history program and devised a new collection development policy for the Academy Library. Prior to his work in New York, Dr. Morman was Librarian of the Institute of the History of Medicine at the Johns Hopkins School of Medicine (1987–1997), and Reference Librarian at the Charles Patterson Van Pelt Library of the University of Pennsylvania (1977–1987). A 1967 graduate of the City College of New York, Dr. Morman earned his library degree at the University of Southern California (1973) and his doctorate in History and Sociology of Science at the University of Pennsylvania (1986). His dissertation was titled *Scientific Medicine Comes to Philadelphia: Public Health Transformed, 1854–1899*. Dr. Morman was the 1986–87 Humanities Fellow in the Department

of Community and Preventive Medicine at the Medical College of Pennsylvania. He has taught undergraduates, graduate students, and medical students at the University of Pennsylvania, the Medical College of Pennsylvania, and the Johns Hopkins University; and has published in the *Bulletin of the History of Medicine*, and *The Pennsylvania Magazine of History and Biography*, among other journals. He has served as the president of Archivists and Librarians in the History of the Health Sciences, and he now sits on the Council of the American Association for the History of Medicine and the editorial board of the *Bulletin of the History of Medicine*.

Short-term Wood Fellowships

The Wood Institute awarded seven short-term fellowships in 2000–01:

Eva Sophia Becsei (Department of History, University of Illinois at Chicago), "Going against the Grain: Peyton Rous and Cancer Research as Contested Knowledge, 1900–1966."

Michael Blackie (Department of English, University of Southern California), "The Rest Cure: Fictions and Culture of Regeneration."

Nancy Cervetti, Ph.D. (Department of English, Avila College, Kansas City, MO), "The Letters of S. Weir Mitchell."

Nadav Davidovitch, M.D. (Department of History of Science, Harvard University), "A Study into the Development of Homeopathy as Opposed to Orthodox Medicine."

Michael Dorn (Department of Geography, University of Kentucky), "Port Wine and Quarantine: Medical Politics and Medical Ethics in the Early American Republic."

Boleslav L. Lichterman, M.D. (Maison des Sciences de l'Homme, Paris), "A Special Field of Surgical Neurology in Philadelphia: from W. W. Keen to Charles Frazier."

Alain Touwaide, Ph.D. (Madrid, Spain), "Byzantine Medicine in Incunabula and 16th-Century Editions."

EDWARD T. MORMAN, M.S.L.S., PH.D.
DIRECTOR, FRANCIS CLARK WOOD
INSTITUTE FOR THE HISTORY OF MEDICINE

The College of Physicians of Philadelphia Financial Report FY2000

I. Commentary

Fiscal year 2000 represented a period of improved financial performance for the College as compared to the previous fiscal year. Museum revenues increased over 30% and revenues from annual giving increased over 34%. The College experienced substantial realized gains on investments totaling $1,940,307. Revenues from library document delivery services decreased by 19%, continuing a trend of decreased activity in this area.

Total revenues increased over 6% and due to tight budgetary control, operating costs decreased by 13%. Total net assets increased by 5%. Accounts payable, a liability representing amounts that the College owes to vendors for services rendered, decreased by 75%.

The trend of improvement in financial performance from operations has continued into fiscal year 2001. The following financial data is excerpted from the audited fiscal year 2000 financial statements prepared by the College's external auditors, Macdade Abbott, LLP.

II. Financial Data

Operating Statement

Revenues	
Membership Dues	$404,755
Contributions and Grants	$571,890
Facility Rental and Parking Lot Lease	$450,239
Endowment Proceeds	$873,812
Services Provided	$414,357
Total Revenues	$2,715,053
Expenditures	
Programs and Services	$978,103
Plant and Depreciation	$451,519
Benefits and Payroll Taxes	$251,310
Management, Accounting, Overhead & Development	$764,087
Total Expenditures	$2,445,019

Balance Sheet

Assets	
Cash	$258,336
Accounts Receivable (net)	$58,373
Notes Receivable (net)	$5,477
Contributions Receivable	$402,192
Investments (market value)	$11,130,810
Other Assets	$42,123
Buildings, Furnishings, and Equipment (net)	$2,352,428
Total Assets	$14,249,739
Liabilities	
Accounts Payable	$113,571
Other Liabilities and Accruals	$521,979
Total Liabilities	$635,550
Net Assets	
Unrestricted (mostly property)	$2,564,676
Temporarily Restricted	$4,992,631
Permanently Restricted	$6,056,882
Total Net Assets	$13,614,189
Total Liabilities and Net Assets	$14,249,739

JOHN B. SAWYER, C.M.A., C.F.M.
CHIEF FINANCIAL OFFICER

Abstracts from the Poster Sessions Sponsored by the Section on Public Health and Preventive Medicine

Use of Perinatal Periods of Risk Model to Investigate Geographic Disparities in Philadelphia Infant Mortality

Authors: Kennen S. Gross, M.P.H. (5/01), MCP-Hahnemann School of Public Health; Linda Hock-Long, Ph.D., Philadelphia Department of Public Health; Michelle Berlin, M.D., M.P.H., Philadelphia Department of Public Health; Jana Mossey, Ph.D., MCP-Hahnemann School of Public Health.

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Member sponsor: Marjorie Angert, D.O., M.P.H.

Background: The infant mortality rate (IMR) does not provide sufficient information to understand the many factors that contribute to the infant mortality rate; more robust analytic methods are needed to guide prevention efforts. One such method, the Perinatal Periods of Risk (PPOR), developed by the WHO and modified by the CDC, utilizes age at time of death, birth weight, gestational age and fetal death to create a matrix that reflects the effect various risk factors have on a community's perinatal mortality.

Objectives: Apply the PPOR method to Philadelphia fetal and infant death records in order to monitor and investigate geographic disparities in infant mortality.

Design/Methods: Philadelphia's 1996–1998 infant birth/deaths records and fetal death records were linked to PPOR cells based on age at death and weight at death. Rates were calculated for each cell by the following formula: # deaths in cell/live births + fetal deaths.

Results: Presented below is PPOR Phase I analysis for Philadelphia as a whole and for Lower North Philadelphia (LNP) and West Philadelphia (WP). PPOR Phase II analysis will be conducted for these areas.

PPOR rates

	Fetal (24+ wks)	Neonatal	Postneonatal
500–1499g	*Maternal care/Prematurity*		
		Philadelphia 5.2	
		LNP 9.1	
		WP 6.0	
1500+ g	*Maternal health*	*Newborn health*	*Infant health*
	Philadelphia	Philadelphia	Philadelphia
	3.0	1.5	2.7
	LNP	LNP	LNP
	4.3	3.0	4.3
	WP	WP	WP
	3.7	1.8	3.5

Conclusions: PPOR analysis provides more information more useful than IMR for analyzing geographic disparities, and can be used to guide maternal and child health prevention efforts.

Cyclospora Infection Associated with a Wedding Reception—Philadelphia, PA 2000

Authors: A.Yang, M. Eberhardt, B. Finkel, B. Herwaldt, A. Lopez, C. Johnson. Department of Public Health (PDPH), Philadelphia, PA, and Centers for Disease Control and Prevention (CDC), Atlanta, GA.

Abstract: The foodborne outbreaks of *Cyclospora* infection that have been recognized to date have been associated with fresh produce, including raspberries, mesclun lettuce, and basil. In 2000, the PDPH and CDC conducted a retrospective cohort study of an outbreak of cyclosporiasis among attendees of a catered wedding reception held on June 10. A case was defined as having attended the reception and either having a positive stool examination for *Cyclospora* or meeting specific clinical criteria. Seventy-nine of 83 wedding guests were interviewed. Fifty-six (70.1%) of the interviewees met the case definition. The median incubation period was 7 days (range, 1–9). Predominant symptoms among cases were diarrhea (93%), nausea (75%), fever (56%), and vomiting (46%). In multivariate analysis, the wedding cake, which had a raspberry-cream filling, was the food item most strongly associated with illness (univariate relative risk, 5.0 [95% confidence interval, 2.3–11.0]. The raspberries had been received fresh by the caterer but were frozen twice thereafter before they were served; they were frozen for several days before the cake was made, thawed, added to the filling of the cake, and then frozen along with the cake for 4–5 days until the cake was

served. Although limited information is available about the effects of freezing on survival of *Cyclospora*, freezing at sufficiently cold temperatures for sufficiently long periods should kill the parasite. No commercially frozen food items have been associated to date with recognized outbreaks of cyclosporiasis. However, this outbreak, which is the latest in the series of springtime outbreaks of cyclosporiasis linked to raspberries, shows that *Cyclospora* can survive less rigorous freezing.

Congruency of Safety Messages in Public Utility Companies' Newsletters with Morbidity Reports on Unintentional Injuries: Opportunity for Health Communications

Author: Stephen F. Gambescia, Ph.D., M.Ed., C.H.E.S. Neumann College.

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Background: Health communications and social marketing have become useful strategies in health education. In Pennsylvania, unintentional injuries are recognized as a cause of much morbidity and disability among all ages. Of the leading health threats, risk reduction strategies for unintentional injuries seem relatively tenable. Extant studies have shown that injuries occur to high-risk individuals, occur in high-risk environments, and involve contact with high-risk agents. The rationale for this study is to assess the use of safety messages targeted to residents of a large metropolitan area and make recommendations from findings.

Objective: The objective of this study is to assess the congruency of safety messages delivered via two public utility newsletters with morbidity reports from the *Injuries in Pennsylvania: Hospital Discharges, 1996*. Ideally safety messages would match the magnitude of the *leading mechanisms* of unintentional injuries.

Design/Methods: Forty "newsletters" from two public utility companies in Southeastern Pennsylvania were received during an approximate two-year period. These "newsletters" accompany the monthly utility bills and therefore have unprecedented *reach* to all owners/renters. The newsletters were screened for unintentional injury safety messages. The *nature, extent, and frequency* of these messages were compared with morbidity data in the *Injuries in Pennsylvania: Hospital Discharges, 1996* report.

Conclusions: Safety messages in these public utility newsletters are not congruent with the observed leading mechanisms of unintentional injuries to

residents of this metropolitan area. Understandably, these safety messages address utility-related risks to life, limb, and property damage. However, no reasonable pattern exists when non-utility related safety messages were printed. Conspicuously absent were safety messages addressing the leading mechanism for conflagration fatalities: cigarette smoking. Strengths, weaknesses, and opportunities for improving these safety messages will be given.

What's the Problem? Meeting the Oral Health Care Needs of At Risk Philadelphia Children

Authors: Merle A. Jones, B.S.N., R.N.; Sharon Starr, M.S.N., P.H.N.

Abstract: Dental caries is the single most common disease in children despite advances in water fluoridation. According to the Surgeon General, *Healthy People 2010*, and the National Institute of Dental and Craniofacial Research (NIDCR), dental care is lacking in 27 million uninsured American children. Philadelphia's low-income population has dental coverage through Medicaid or the State Child Health Insurance Plan (CHIP) when they are up to 200% of the poverty line. Yet, these children are not accessing oral health care. The objectives of this study are to identify policies and community and personal barriers that influence oral health care access, and to concurrently educate parents and communities about this public health issue.

Surveys of key community and governmental informants, dental offices, and parents are described and analyzed for policy trends. Dental health education was provided to children under age six and to parents. Parental education was followed with focus group questions to provide further analysis of oral health concepts, values, stated behaviors, and awareness of existing community resources.

This two-semester graduate public health nursing project encompasses multilevel strategies to improve the oral health care of Philadelphia children six years and younger. The problems of access to care in this urban area are described in this paper, as are the educational initiatives targeting children in day care settings and their caregivers. Formative and summative evaluation of this public health project will provide the framework for future policy development and public health approaches to promote optimal dental care for low-income children and their parents.

Local Health Department and School of Public Health Collaborate to Improve Population Health and Train Students

Authors: Nathalie A. Bartle, Ed.D., Associate Dean and Associate Professor, MCP-Hahnemann SPH; Augusta Villanueva, Ph.D., Assistant Professor, MCP-Hahnemann SPH; Linda Lloyd, Ph.D., Associate Dean, Assistant Professor, MCP-Hahnemann SPH; David Tollerud, M.D., M.P.H., Professor, MCP-Hahnemann SPH; Walter Tsou, M.D., M.P.H., Commissioner,

Philadelphia Department of Public Health; David Webb, Ph.D., Director of Research and Evaluation, Philadelphia Department of Public Health.

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Background: In 1996, the School of Public Health (SPH) admitted its first class of MPH students. The School was founded on the principles of an integrated problem-based learning approach to teach the five disciplines of public health and the promotion of public health practice skills and service learning, with strong support from community-based organizations—in particular, the Philadelphia Department of Public Health (PDPH).

Objectives/Program Design: A natural development of the core values and first-year community experiences was the development of the Community-Based Masters' Project (CBMP) program for second-year students. Program goals include: (1) enhance knowledge in core public health disciplines; (2) develop public health practice skills; (3) develop research skills relevant to academic concentration; (4) address a community need to improve population health; and (5) promote human rights. This CBMP program has from its inception built strong working relationships with the PDPH; in the first three years of the program, 19 students conducted CBMP projects with PDPH preceptors.

Results: Formative evaluations indicate that the PDPH has benefited from having students address important issues that "they have never had time to do," and build relationships among students, faculty and PDPH personnel. Students have benefited from community preceptor mentoring, improving practice skills, and learning how to design and complete a comprehensive project.

Conclusion: Numerous benefits have accrued to the PDPH, the students and the SPH. These benefits may be enhanced further by developing joint training of PDPH and SPH preceptors; identifying on-going projects; and further clarifying each partner's roles, responsibilities, and benefits.

Inner-City Children at Age 9: An Age of Innocence?

Authors: Hallam Hurt, Elsa Malmud, Nancy L. Brodsky and Joan Giannetta. Pediatrics, Division of Neonatology, Albert Einstein Medical Center, Philadelphia, PA.

Background: Urban youth are considered "street-wise" and frequent participants in risk behaviors; few such data, however, are available for young inner-city children. In a cohort of inner-city children followed since birth, we reported a high exposure to neighborhood violence and substance use by age 7; we now report data regarding risk behaviors in these children at age 9.

Objective: To evaluate young inner-city children's knowledge of and participation in risk behaviors.

Design/Methods: At age 9 children are administered the Youth Health Risk Behavior Inventory (YHRBI), a questionnaire assessing knowledge of, participation in, and opinions about high-risk behaviors. A psychologist reads questions to the children who respond verbally.

Results: Selected results from 53 children, 49% female, with mean age 9.2±0.2 yrs follow:

> KNOWLEDGE: On questions regarding AIDS and pregnancy, mean percentage correct is 14.5±26.2. Fewer than 26% of the children know that anyone can get AIDS, that AIDS is caused by a virus, and that people with AIDS die. 87% of children do not know one can get pregnant with first-time sex or if a condom breaks.
>
> PARTICIPATION: 47% never use bike helmets; 49% have had a physical fight with a friend (but only 1/53 joined friends to beat up someone unknown to them); 6% have been suspended at least once; 17% have seriously thought of suicide; 4% made a plan, but none have attempted suicide. Drug activities: 4% have smoked cigarettes; 21% have had alcohol; none report use of marijuana or cocaine, or selling or delivering drugs.
>
> OPINIONS: 80% of children say if a friend used drugs or drank, they would not; 90% feel it is unlikely they will use or deal drugs when they are older; 98% do not think they will be arrested when they are older; 51% feel they are one of the best students in their class; 90% feel they will go to college or trade school.

Conclusions: (1) Inner-city children at age 9 present with a paucity of information regarding two high-risk behaviors; (2) cohort children participate in some common risk behaviors of childhood, but admit little experience with substance use or substance-related activities; (3) children express a poignant idealism regarding themselves and their future.
Speculations: Age 9 may be an opportune age not only for education of children regarding risk behaviors and their consequences, but also for reinforcing positive goals and ideals.

Disclosure: Funded by Einstein Society and NIDA #DA04965.

Children with Gestational Cocaine Exposure (COC) Differ from Unexposed Controls (CON) in Attentional Processing

Authors: Hallam Hurt, Elsa Malmud, Nancy L. Brodsky and Joan Giannetta, Division of Neonatology, Albert Einstein Medical Center, Philadelphia, PA.

Background: Animal models suggest that in utero cocaine exposure may affect developing dopaminergic systems that, in turn, may be critical to attentional reactivity. As attentional problems have been suggested in COC, we evaluated this outcome in a cohort of inner-city term and near-term COC and CON children followed since birth.

Objective: To assess attentional processing in COC vs. CON.

Design/Methods: 24 COC (median 99 days in utero exposure) and 16 CON were evaluated at age 10 yrs. by a masked examiner on three measures of attention: (1) Gordon Diagnostic System (GDS), a visual computerized test measuring impulsivity and sustained attention through 3 tasks (Delay, Vigilance, and Distractibility) that pose conditions of increasing arousal/stress as the participant progresses from Delay to Distractibility; (2) Trail Making Test (Trails), a classic measure of attention and cerebral efficiency; and (3) Seashore Rhythm Test (Seashore), a classic measure of auditory attention. Child Behavior Checklist-Teacher Report Form (CBCL-TRF) and child IQ scores were also obtained.

Results: At birth, COC and CON did not differ in Apgar scores (all p=.54), and all except one CON had normal cranial ultrasounds (p=.40). Full Scale IQ scores and CBCL-TRF were also similar in COC and CON (all p=.40), with no clinically significant behavioral syndromes noted, including inattention. The GDS Delay Task showed COC and CON did not differ (p=.37), with both scoring in the normal range. COC and CON were also similar on the Vigilance Task (p=.35); however, neither group was able to sustain age-appropriate attention or self-control. For Distractibility, CON were more attentive (p=.023) and less impulsive (p=.018) than COC. On Trails, both COC and CON performed poorly (moderately to severely impaired), but groups did not differ (p=.54). Both COC and CON also performed poorly on Seashore, but did not differ (p=.26).

Conclusions: (1) COC are more inattentive and impulsive than CON under conditions of high arousal. (2) COC and CON exhibit impairments in cerebral efficiency and fluctuations in visual and auditory attention. (3) COC and CON are not identified as having attentional or behavioral problems in the classroom.

Comment: The altered stress responsivity found in COC supports theories linking gestational cocaine exposure to alterations in developing dopaminergic pathways.

Disclosure: Funded by Einstein Society and NIDA #DA04965.

Using Surveillance to Evaluate Missed Opportunities to Prevent Perinatal Hiv Transmission

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Abstract: Perinatal HIV transmission can be reduced by accessing prenatal care, knowing the woman's HIV status as early in pregnancy as possible, and using antiretroviral agents and appropriate obstetrical practices. Since the results of the PACTG 076 clinical trial showed that AZT can reduce the risk of perinatal HIV transmission, the New Jersey Department of Health and Senior Services (NJDHSS) has actively promoted implementation of interventions to prevent perinatal HIV transmission. The NJDHSS HIV/AIDS surveillance system evaluates perinatal HIV transmission. Perinatal HIV transmission has decreased from 21% of perinatally exposed children in 1993 to 8% in 1998. A total of 10 children to date have been identified as being infected with HIV through perinatal transmission in 1999 and 2000. Of these 10 children, 4 (40%) had no known prenatal care; 1 (10%) had prenatal care, antiretroviral agents, and a c-section; 1 (10%) had prenatal care starting in the last trimester without AZT and a vaginal delivery; 2 (20%) had prenatal care starting in the third trimester with AZT with 1 delivering vaginally and 1 delivering by c-section; 1 (10%) had prenatal care starting in the second trimester, but no AZT and a vaginal delivery; and 1 (10%) had prenatal care, but had a negative HIV test early in pregnancy (the child tested HIV negative at 4 months of age, and was breast fed).

No known or inadequate prenatal care is the major gap identified among the children who became infected. An advisory committee has been developed to review all cases of perinatal HIV transmission. Outreach efforts have been implemented to encourage women to access prenatal care. An ongoing statewide educational intervention is continuing. A statewide policy to offer the rapid HIV diagnostic test and short course therapy for women who present in labor with unknown serostatus is being developed. Surveillance activities will continue to be used to evaluate the implementation and effectiveness of recommendations to reduce the risk of perinatal HIV transmission.

Reducing the Risk of Perinatal Hiv Transmission: A Needs Assessment and Action Plan for Updated Hospital Policies

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Abstract: Reducing perinatal HIV transmission is a public health priority in New Jersey. Perinatal transmission accounts for over 95% of pediatric HIV and AIDS cases in New Jersey. The major gap identified in New Jersey in reducing the risk of perinatal HIV transmission is that 25% of HIV infected pregnant women have no known prenatal care. National recommendations for rapid HIV diagnostic testing and short course therapy for women who present in labor with unknown HIV serostatus were disseminated. A telephone survey to determine implementation of these recommendations was conducted in 12 hospitals in Newark, Jersey City, and Paterson. Of the 9 responding to the survey, 6 provide in-patient obstetrical services. None of the hospitals offer rapid testing and short course therapy. Only one hospital has the laboratory capability to perform the rapid test. As a result of this survey, a multi-faceted intervention was planned including: (1) an advisory committee has been meeting to develop a statewide model policy to offer rapid testing and short course therapy, (2) an educational conference was held, and (3) the hospitals have been offered a one-hour free continuing medical education lecture. A repeat survey is planned to assess the impact of intervention.

Identifying Intervention Areas and Establishing Morbidity Thresholds for Syphilis Elimination in Philadelphia, PA

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Background: Identifying well-defined geographic areas for targeted interventions will focus elimination efforts in communities where outbreaks are likely to occur. Establishing morbidity thresholds will help detect outbreaks.

Objective: To identify geographic areas where targeted interventions will have the most impact, and establish thresholds of disease morbidity for early detection of outbreaks.

Design/Methods: Morbidity data for primary and secondary syphilis cases between 1991 and 1998 (n = 3694) were analyzed using Geographic Information Systems (GIS) software. The city was divided into a grid made up of 165 one-square-mile blocks and cases were plotted by patient address. Case counts were calculated by grid block and those blocks with the greatest number of cases for each year of the analysis were identified as potential intervention areas. City-wide thresholds for one-week and four-week periods were calculated using the most recent 20 months of data (1998 and the first eight months of 1999). Thresholds were set city-wide and by age category, race, diagnosis, gender, MSM status, and geographic area.

Results: Between 1991 and 1998, ten one-square-mile blocks accounted for 1,428 cases of infectious syphilis, or 39% of total morbidity. Five of these blocks, accounting for 23% of total morbidity, were selected as intervention areas. Citywide thresholds for infectious syphilis morbidity were set at 2.68 cases for one week and 8.6 cases for a four-week period.

Conclusion: Spatial analysis can be used to identify geographic areas for targeted interventions. Thresholds can be used to define and detect outbreaks based on demographic and geographic criteria.

Syphilis Outbreak Among Men Who Have Sex with Men (Msm)—Philadelphia, Pa

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Background: During the first seven months of 1999, 28 infectious syphilis cases among men were reported to the STD control program. Of these cases, 39.3% (11/28) occurred among men who have sex with men (MSM—sexual orientation based on self-reporting). Since 1995 there has been an increase in both the number and percentage of infectious syphilis attributed to MSMs in Philadelphia (1/110, 0.9% in 1995 to 11/45, 19.6% in 1998).

Objective: To reduce the number of infectious syphilis cases occurring in the MSM community by developing an effective intervention strategy specifically designed for the affected population.

Design/Methods: The eleven infectious syphilis cases were analyzed to discern the social and sexual behaviors associated with the increased risk of acquiring syphilis. These data were presented to Community Based Organizations representing the MSM community and to the AIDS Activities Coordinating Office. A press release was formulated and the information was disseminated to the affected community via an article in a local MSM oriented newspaper. The STD program went into the community, distributed condoms, posters, and educational materials to businesses that served the community, and provided syphilis screening.

Results: The number of reported infectious syphilis cases in the MSM community sharply declined; during the remainder of 1999 (August through December) and during CY 2000 five cases were reported.

Conclusion: An intensified, collaborative effort between public health and key community resource providers representing the MSM community aided in reducing the number of reported cases of infectious syphilis in this population.

Surveillance for Chlamydia Among Adolescent Males in the Juvenile Detention Center—Philadelphia, Pa

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Background: Historically, routine chlamydia screening has been aimed at women to prevent PID and infertility; however, no comparable screening program exists for males. Consequently, men accounted for only 17.2% of chlamydia cases reported in 1999, suggesting that asymptomatic, untreated males represent a significant reservoir of infection. This is consistent with data describing high rates of infection and reinfection among 15- to 19-

year-old females and supports screening targeted to their male counterparts. The Juvenile Dentention Center (JDC) was selected as one screening site.

Objective: To identify and treat adolescent males with *C. trachomatis* detained in the JDC; to determine the prevalence of infection among this population.

Design/Methods: Upon admission to the detention center, all adolescent males are offered urine-based chlamydia testing. Positive test results are faxed to the provider for treatment. All test results (negative & positive) are entered into the STD program's database. All adolescents released prior to treatment are provided with field follow-up by the STD Program's Disease Intervention Specialists to ensure treatment.

Results: Testing was initiated on December 13, 1999. Through October 13, 2000, 3,568 adolescent males were screened for chlamydia; 308 chlamydial infections were identified for a positivity rate of 8.6%. Adequate treatment has been confirmed for 60% (184/308) of these cases.

Conclusion: Screening adolescent males in a juvenile detention center for *C. trachomatis* may be an effective method to identify and treat asymptomatic chlamydial infections.

Impact of the Varicella Vaccine on Disease in West Philadelphia

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Background: Funded by the Centers for Disease Control and Prevention, the Philadelphia Department of Public Health (PDPH) has been monitoring and collecting data on varicella cases in West Philadelphia through a comprehensive, active surveillance system, since October 1994. With this surveillance system in place, the PDPH has been able to document and describe the occurrence and epidemiology of varicella among the approximately

300,000 persons in West Philadelphia before and after the varicella vaccine became available.

Objective: To describe the impact of vaccine on the occurrence and epidemiology of varicella in West Philadelphia.

Methods: Clinical and epidemiological survey data collected during the investigation of varicella cases in West Philadelphia from October 1994 through December 2000, along with National Immunization Survey data for varicella vaccine coverage, were used to examine the impact of varicella vaccine on disease.

Results: 3,556 varicella cases were reported from October 1994 through December 2000, with 261 cases occurring in the last quarter of 1994 (1,197 in 1995; 579 in 1996; 605 in 1997; 410 in 1998; 271 in 1999; and 233 in 2000). Reported varicella case rates in West Philadelphia decreased from 4.1 per 1,000 population in 1995 to 0.8 per 1,000 population in 2000. Since vaccine licensure in 1995, varicella vaccine coverage rates for Philadelphia among children 19 to 35 months have increased from 43% in 1997 to 75% in 1999 and have remained level at 76% for the first half of 2000.

Conclusions: As varicella vaccine coverage has increased, the occurrence of varicella disease in West Philadelphia has decreased.

Barriers and Enabling Factors of Breastfeeding—A Quantitative and Qualitative Analysis

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Abstract: Mothers today are presented with a myriad of choices, desires, obligations, and constraints in deciding how to feed their infants. Despite the mounting research that documents the compelling advantages of breastfeed-

ing to infants, mothers, families, and society, current breastfeeding rates worldwide are far from optimal, particularly among low-income women. This study attempts to determine the major barriers and enabling factors for breastfeeding among low socioeconomic populations of mothers residing in Orange County, CA, and Philadelphia, PA. Two complementary sources of data—quantitative and qualitative interviews—were used to examine the relationships between breastfeeding initiation and duration and the following variables: ethnicity, education, socioeconomic status, age, post-delivery work or educational status, and previous breastfeeding experiences. A convenience sample of 675 mothers in Orange County, CA, completed a structured questionnaire, and a convenience sample of 25 mothers in Philadelphia, PA, participated in semi-structured qualitative interviews. Analyses of the quantitative data will provide descriptive statistics for the study population, whereas analyses of the qualitative data will permit in-depth insights into the knowledge, beliefs, and feelings of mothers. Preliminary findings suggest that differences do exist among mothers who were currently breastfeeding or had breastfed in the past and mothers who had never breastfed. By attempting to further identify the barriers and enabling factors of breastfeeding for specific populations of women, it may be possible to address the issue of what needs to change in terms of health education and policy so mothers can recognize the importance of breastfeeding for both their babies and themselves.

**Note:* The presenter is working on this study for her community-based Master's project and will be completing it by the end of April, 2001. Results will be tabulated and conclusions will be made prior to the poster session on May 2, 2001.

Health Intervention Program for Families: Community Partnership Providing Family Health Interventions

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Abstract: Maternal child health home visitation has been shown to effectively assist young families and their offspring in navigating health care systems. LaSalle Neighborhood Nursing Center has provided family health home visitation since 1993 with Philadelphia Department of Health, Office of Maternal Child Health funding. In 1998, the Department of Health modified LaSalle's home visiting program in both target population and parameters of client service. This program, Health Intervention Program for Families (HIP), connected LaSalle with two other home visiting agencies pro-

viding services throughout the city and with two city-wide agencies traditionally serving child welfare and drug and alcohol agencies who were interested in further expanding services for their clients. The Health Department, with mandated uniform record keeping and increased data collection and submission, more centrally controlled HIP services. The agencies developed their programs with the Health Department to reflect a coordinated city-wide effort to meet high-risk family needs. Case studies will be used to describe the HIP interagency collaborations used to provide services to children at health risk and their families who have psychosocial risks. These activities will demonstrate the nature of services provided in a collaborative network.

An Assessment of Adolescent Susceptibility to the Varicella-Zoster Virus in Absentee and Attendee Populations in West Philadelphia Middle Schools

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Background: In the spring of 2000, the Philadelphia Department of Public Health conducted a survey to determine varicella susceptibility rates in West Philadelphia middle-school adolescents. The sixth grade classes were selected as the population for the survey. Upon inspection of the data collected, it was noted that approximately 30% of the students eligible for the survey were absent on the day it was administered.

Objective: To determine if the susceptibility to varicella is different for the absentee population when compared to the attendee population.

Methods: Absentee students were identified using the Philadelphia Department of Public Health and school records. A sample of the absentee students representing three different middle schools from three different clusters were surveyed to determine if they have had varicella disease or if they had been given the varicella vaccine (VARIVAX).

Results: The absentee population was comprised of 882 students. The absentee sample consisted of 272. 71.3% of the absentee sample reported a positive history of varicella disease, as did 73.9% of the students surveyed in the spring. 23.5% of absentee students were classified as susceptible to varicella disease, as was 20% of the spring survey sample.

Conclusions: Analysis of the survey results suggests that there is no difference in the susceptibility to varicella between the absentee and attendee populations.

Preventable Invasive Pneumococcal Disease and Missed Opportunities to Immunize in Hospital

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Background: Pneumococcal disease accounts for more deaths than any other vaccine preventable disease. Despite availability of vaccines, patients hospitalized with conditions for which pneumococcal vaccines are indicated are not routinely vaccinated.

Objective: To determine the incidence of invasive pneumococcal disease at Albert Einstein Medical Center and evaluate the documentation and use of pneumococcal vaccine over a three-year period.

Methods: Patients with invasive pneumococcal disease admitted between September 1, 1997, and September 30, 2000, were identified by a hospital computer database. Microbiology records were reviewed for identification of *Streptococcus pneumoniae* isolates from sterile sites. Inpatient vaccine administration within 5 years was obtained from the main pharmacy database. Data were analyzed using SPSS statistical software.

Results: A total of 70 patients with a mean age of 54 years (range 19 to 94) had invasive pneumococcal infections and 66% (46/70) had at least one previous hospitalization within 5 years; none had received pneumococcal vaccine during a previous hospitalization. Of these 70 patients, vaccine was recommended for only 24% (17/70) with 65% (11/17) receiving vaccine prior to discharge.

Conclusions: Current strategies used to assess and administer pneumococcal vaccine are inadequate in this institutional setting.

A Cluster of Primary Varicella Cases in HCWs with False-Positive VZV Titers

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Background: During 2000, five cases of primary varicella zoster virus (VZV) infection were diagnosed in healthcare workers (HCWs) from the same hospital. All five infected HCWs had complied with the hospital's pre-employment VZV testing program and were believed to be immune at the time of exposure.

Objective: To summarize the investigation of five cases of VZV in un-immunized HCWs and to provide recommendations for avoiding false-positive serologic tests.

Results: Over the year, five HCWs were presented with typical vesicular rashes and systemic symptoms consistent with primary varicella infection. Four had known VZV exposures 2 weeks prior to presentation. All had documented positive VZV titers by latex agglutination (LA) from their dates of hire. None had been offered pre-hire VZV vaccination based on their positive titers. Confirmatory testing for varicella was positive in all infected HCWs. The original LA tests were judged false-positives.

Follow-up Investigation: 53 consecutive samples sent to the hospital lab for VZV LA testing were re-tested at the CDC in October 2000. 44 were positive by LA at the hospital lab and positive by IgG ELISA at the CDC. Of the remaining nine, four were positive by LA at the hospital lab and negative by IgG ELISA at the CDC. Four were equivocal for LA at the hospital lab and negative by IgG ELISA and LA at the CDC. One was positive by LA at the hospital lab, but negative by LA and equivocal by ELISA at the CDC.

Conclusions: Within one year, five HCWs with documented positive LA for VZV developed primary varicella infection. Follow-up testing found false positive or equivocal results in 9 of 53 specimens (17%). LA appears inadequate to identify VZV vaccine candidates and to prevent nosocomial infection. Whole cell ELISA is a superior test for HCWs.

Factors Influencing Utilization of Interest Free Loans for Abortions

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Abstract: The decision to have an abortion is complex. Low-income women are further conflicted by the financial burden of the procedure. Since the passage of The Hyde Amendment in 1976, Medicaid has ceased funding abortions. In response, the Greater Philadelphia Women's Medical Fund was established to provide interest-free loans to low-income women and teenagers who need financial assistance to obtain a legal abortion. The Greater Philadelphia Women's Medical Fund's 1999 annual report reveals that the utilization rate for vouchers is approximately 75%. The purpose of this Masters of Public Health project was to discern why 25% of women decide not to use the voucher. Improving services and access to services in this area was the long-term goal. Women who applied for loans from January 2000 to October 2000 were surveyed by phone, as were the administrators of the contracting abortion centers. Their responses are reported against the backdrop of decision-making theory. The long-range goal of this project is to improve the services of the Greater Philadelphia Women's Medical Fund and to ultimately improve access to these services.

Male Adolescent Project Using Self-Reported Health Beliefs and Perceptions to Design a Health Education Intervention Model

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Abstract: Many research studies have analyzed epidemiological and quantitative data related to health issues among adolescent males. Studies addressing violence, sexual behaviors, and the predictors associated with these outcomes have been researched and published for this population. However, a review of research literature does not reveal many studies that assess the self-reported health beliefs and perceptions of adolescent males. This project aims to develop a health education intervention model for African American and Latino adolescent males 13–18 years old, based on self-reported health beliefs and perceptions. The project design utilizes focus groups conducted among the target population to collect data. Data analysis includes: identifying themes from the focus group discussions, reviewing results collected from survey instruments administered among adolescent males that address the related health themes, and reviewing existing intervention methods and models to determine feasibility of proposed project methods. Examination of focus group themes, results from selected survey instruments, as well as existing intervention methods and models will be presented. A combination of qualitative and quantitative data collected from minority adolescent males may help to develop a more inclusive picture of those health concerns most important to the target population. The self-reported health concerns identified as most important can be incorporated into a health education intervention model that might prove to aid in healthier outcomes for minority adolescent males.

Using the School Health Index to Promote Healthy Eating and Physical Activity among Urban Middle-School Students

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Background: Increased sedentary lifestyles among children and adolescents have challenged schools and communities to develop fun, innovative approaches to coordinated nutrition and physical education programs. School health education can play an important role in promoting changes in student attitudes and behaviors about health promotion and disease prevention. Improving the health and fitness of youth requires a multifaceted scheme of developing healthy skills and supportive learning, while reinforcing positive

school experiences. Since eating habits and physical activity are influenced by many factors, strategies should target multiple areas within the school environment. The Centers for Disease Control and Prevention's "School Health Index (SHI) for Physical Activity and Healthy Eating," is a tool to assess the strengths and weaknesses of school health policies and environment, and to strengthen school health initiatives. In an effort to enhance the School District of Philadelphia's capacity to improve student health, a pilot project will be conducted at an urban middle school.

Objectives: The objectives of the project are to: (1) Assess the strengths and weaknesses of one Philadelphia middle school's health promotion policies and nutrition services using the SHI, (2) identify and prioritize recommendations to develop an action plan for a healthier school environment, (3) analyze the effectiveness of using the SHI to assess and plan school health improvements, and (4) develop SHI implementation guidelines for the School District of Philadelphia.

Design/Methods: The data will be collected through utilization of the School Health Index.

Results: At this time, results are unavailable for the study.

Conclusions: Conclusions cannot be drawn.

Formative Evaluation of the Integration of the Collaborative Model of Care in a New Family Practice Center in Ukraine

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Abstract: In countries of the former Soviet Union, persons affected by mental disorders tend to avoid the psychiatric system because of the stigma attached to it and traditional primary care services aren't adequately prepared to manage mental disorders effectively. The traditional model of care, rigidly hierarchical and physician-centered, hampers effective case management. Temple University received a partnership grant from the American

International Health Alliance to assist in the development of community-based primary care in Kyiv, Ukraine. One of the goals of the Kyiv-Philadelphia Primary Healthcare Partnership is to develop a collaborative model of care that would integrate mental health services into a multidisciplinary primary care team. A Family Practice Center opened in Kyiv in October 2000 and is offering mental health services based on a collaborative approach. The current paper presents an evaluation of the results of the multidisciplinary team building through a bilateral approach that involved a survey of mental health referral patterns and interviews with primary care professionals regarding the quality of collaboration between medical and mental health providers. The results are presented in the context of the Health Belief Model and suggestions for improving team functioning are offered. Preliminary results suggest that, although there is a considerable interest for adopting the collaborative model, the traditional approach to physician-driven healthcare delivery is difficult to overcome and more training is needed in areas such as interdisciplinary communication and team-based decision-making.

Assessing an Internet-Based Support Group for Chronic Hepatitis B Carriers: Exchanging Information and Support Online

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Abstract: Hepatitis B is a serious chronic liver infection that can lead to liver failure, cirrhosis, or liver cancer. For 1.25 million Americans, the difficulties and stresses of living with chronic hepatitis B can be overwhelming. It is important that these individuals have access to disease and lifestyle-related information, as well as social support. Hepatitis B carriers are often unable to participate in face-to-face support groups due to illness-related, practical, or personal barriers. Electronic support groups (ESGs) offer members of hard-to-reach populations the opportunity to exchange information and support in a convenient and cost-effective manner. However, little is known about the impact of ESGs on the lives of those who participate.

This study evaluated an online support group for chronic hepatitis B carriers. An online survey assessed the informational and supportive role the

ESG plays in the lives of participants. Data were collected in the following areas: member motivation for joining the ESG, level of comfort with online self-disclosure, medical and lifestyle changes made as a result of participation, and the level of successful support exchanged among group members. Survey data indicate that group participants turn to the ESG for the majority of their information and support needs. An analysis of 160 group e-mails revealed that the topics of diagnosis, nutrition, disease progression, and treatment were most commonly discussed. Study results will be used by the Hepatitis B Foundation to develop educational packets for chronic carriers. This study offers new insight into the information and support-seeking behaviors among ESG participants.

Training 3 Resource Needs

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Member Sponsor: Alice Hausman, Ph.D., M.P.H.

Abstract: TRAINING 3 provides training to employees of Title X funded Family Planning clinics in Region III of the United States. Although training of clinic staff is essential to the effective delivery of reproductive health care and contraception, many clinics cannot afford to send staff to training and/or cannot afford for staff members to be out of the office at training. TRAINING 3 created a lending library of videos, books, and other resources to be lent to staff in the region, in place of or in addition to attending training sessions. Until this time, however, no formal needs assessment has ever been conducted with this population to determine the types of resources that should be included in the lending library. This survey, which was sent to all clinics in Region III listed in the Family Planning Grantees, Delegates and Clinics Directory, assessed respondents' likelihood to use the lending library resources, topics of interest, and barriers to receiving training. Results of this survey will be presented, including comparisons of responses among various geographic areas within the region, among various job categories, and among various family planning settings.

A Profile of Student Health Risk Behaviors and Attitudes at a Small Private Liberal Arts University in Central Pennsylvania

Author: Elizabeth C. Bernabeo, Temple University.

Member Sponsor: Alice J. Hausman, Ph.D., M.P.H.

Abstract: Research efforts to identify health behaviors at the collegiate level have increased drastically over the last decade. National and local institutions alike have collaborated and identified the most prevalent health behaviors practiced by college students. A department was established at a private liberal arts institution in Central PA to address these health behaviors and to implement health promotion and prevention programs to the student body. However, a paucity of data pertaining to the student body limits the department from implementing programs specifically designed to serve the university's needs. This project will collect data on a multitude of health behaviors currently practiced by students, including alcohol/drug use, stress, sexual health, diet/exercise, nutrition, and violence/campus safety. A questionnaire including items identified through the National College Health Risk Behavior Survey will be administered to a purposeful sample of students. Results will be analyzed for frequencies and relationships between health behaviors and factors such as housing, membership in a fraternity or sorority, marital status, age, and class year. The results will be utilized to design future health promotion and prevention programs at the university, and additional data will be collected for purposes of comparing the data to national objectives presented in Healthy People 2010.

Revising the Oral Contraceptive Patient Package Insert (Ppi): Field-Test and Evaluation

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Abstract: Over 10.4 million women in the United States use oral contraceptives (OCs). The FDA requires that OC packages contain a Patient Package Insert (PPI) to provide information directly to patients about the use and safety of OCs. The current PPI is written at a 10–12th grade reading level, utilizes a small typeface, and has indistinct section headings, mak-

ing it difficult for patients to find specific information. This project was conducted to improve the PPI so that information can be found, read, understood and applied safely and effectively by OC users, and also to assess the revised PPI's utility as an educational tool for providers of reproductive health care. Several versions of the PPI were developed and field-tested with 94 family planning clients by members of the project team at three Philadelphia area clinics. Clients were interviewed one-on-one and provided opinions of the language in sections related to use and safety, and were asked to explain the information from the PPI in their own words. Additionally, over 40 experts from the fields of health communications, literacy and reproductive health, pharmaceutical manufacturing, and clinic staff reviewed and provided input on PPI revisions. Finally, a survey of family planning clinic staff examined their current use of the PPI and assessed opinions on the utility of the revised PPI as an educational tool in counseling patients and training staff. Feedback from all groups was incorporated into the final document, written at a 5.3 grade reading level. The final PPI was submitted to FDA for consideration.

HIV/AIDS Knowledge and Attitudes in First- and Second-Year Medical Students

Authors: Julianne Falleroni, Philadelphia College of Osteopathic Medicine; Rachel Kerner; Harry Morris, D.O., M.P.H.

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Abstract: The family physician is one of the most important figures in preventative medicine. Patients' decisions about healthcare and preventative practices are dependent, not only on their cultural and societal perceptions, but also on the information and advice of their primary care physician. Truthful and objective education and counseling necessitate that physicians be knowledgeable in current events, legalities and their community's attitudes toward AIDS. In order to estimate the basic HIV/AIDS knowledge, Srulevich (2000) conducted a pilot study administering a ten-item survey to Philadelphia area medical students. The current study has been motivated by their preliminary results.

In a continuing effort to assess the general HIV/AIDS knowledge and perspectives of future physicians, first- and second-year medical students (N=317) were given an eighteen-question survey. The questions examined basic medical facts including modes of transmission and students' ability to categorize body fluids according to their infectious potential. In addition,

awareness of current events, legal accountability, and personal and societal attitudes toward sex were assessed.

Correct responses will be calculated and analyzed with respect to gender, age, and class year. Personal attitudes and perceptions of societal views toward sex will also be evaluated. These data will be presented with recommendations for the improvement of current continuing medical education programs and future medical school curriculum.

Reference: Srulevich, M., Brownstien, L., Zienkiewicz, J., Templer, S., Falleroni, J., and Rosenblatt, R. (2000). Basic HIV/AIDS knowledge among Philadelphia-area medical students. Poster presented at College of Physicians Section on Public Health and Preventive Medicine, April 5, 2000. Philadelphia, PA.

First Aid Stations as Sites for Infectious Disease Surveillance: Monitoring for Bioterrorism during the 2000 Republican National Convention, Philadelphia, Pa

Authors: Chad P. Schaben, M.P.H., Esther D. Chernak, M.D., Caroline C. Johnson, M.D., Crawford Mechem, M.D., and Robert Levenson, M.B.A. Philadelphia Department of Public Health (PDPH), Philadelphia Emergency Management Services (EMS), and Centers for Disease Control and Prevention (CDC).

Background: During the 2000 Republican National Convention (RNC), the Philadelphia Department of Public Health (PDPH) and Centers for Disease Control and Prevention (CDC) collaborated with the Philadelphia Emergency Management Services (EMS) to conduct infectious disease (ID) surveillance.

Objective: To detect ID outbreaks in the Philadelphia area, monitor for possible bioterrorism, and describe medical consequences associated with this event.

Methods: During the surveillance period Philadelphia EMS established 11 first-aid stations at RNC-related venues in Philadelphia. EMS staff gathered demographic and medical information on patient visits to these stations, and data were analyzed by the PDPH/CDC team. Personal identifiers were omitted to maintain confidentiality. Data were entered into a Microsoft Access database and analyzed using Epi Info 6.0.

Results: There were 169 visits to the first-aid stations during the surveillance period. Most frequent diagnoses were musculo-skeletal injury (46, 27.2%), heat-related illness (32, 18.9%), lacerations (16, 9.5%), and gastroenteritis (13, 7.7%). Forty-seven (27.8%) people were transported to hospitals.

Most frequent transported diagnoses were gastroenteritis (7, 15.9%), heat-related illness (6, 13.6%), and fractures/sprains (5, 11.4%). Twenty-nine (17.1%) people were seen with gastroenteritis, neurologic, rash and respiratory diagnoses combined. No clusters or outbreaks of infectious disease were identified through this surveillance system.

Conclusions: Surveillance conducted through EMS-staffed first-aid stations was a useful way to recognize illness in individuals related to the convention, and to describe the medical consequences for persons associated with a large special event. These data may be used to identify possible infectious disease outbreaks, and to guide health services planning for subsequent events.

The Jefferson Elect Program: Helping Support Teen Parents' Medical, Educational, and Social Needs

Authors: Rituparna Das, Jefferson Medical College; Kara Black, Jefferson Medical College; Cheryl Phillips, M.S., ELECT Coordinator, South Philadelphia High School; and George Datto, M.D., Jefferson ELECT Director, Children's Health Center.

Member Sponsor: Dr. Max Koppel

Abstract: The Philadelphia High School ELECT Program (Education Leading to Employment and Career Training) operates school-based Pregnant and Parenting Teen Centers at each of the twenty-two school district's comprehensive high schools. The aim of these centers is to provide special services, academic alternatives, and career and life skills training to meet the unique needs of teenage parents attending the city high schools. In accordance, Jefferson Medical College and the Children's Health Center at Jefferson have established a relationship with the ELECT Program. The goals of the Jefferson ELECT Program are: to provide basic information on a variety of health-related topics; create a forum for teen parents to discuss their medical questions and concerns; expose students to career opportunities in the health care fields; and encourage students to maintain a continuous relationship with their own healthcare providers.

Since 1998, the Jefferson ELECT Program has held monthly seminars on a variety of topics at South Philadelphia, Ben Franklin, and Furness High Schools throughout the school year. These seminars are designed and given by medical students and pediatrics residents, and attended by approximately 5–15 students and the ELECT coordinator at each school. Topics have ranged from nutrition and child development to STD-awareness and medical careers. The seminars are designed in an interactive format, often including games and role-playing to make the information more accessible to the students, and foster a sense of community among them. The seminars are often driven by questions from the students, and an emphasis is placed on encouraging safe and healthy behavior, rather than giving medical advice.

Responses from students, gathered on a case study basis, have been largely positive, with the best responses from students who have been regular in their attendance of the seminars. Surveys of the ELECT coordinators have also indicated a benefit of students developing longitudinal relationships with the medical student coordinators and pediatric residents. Future directions of the Jefferson ELECT Program include expansion to other high schools and developing opportunities for more one-on-one mentoring.

Presidential Health and the 25th Amendment: Studies of the College of Physicians of Philadelphia

ARTICLE XXV

(proposed 6 July 1965; declared ratified 10 February 1967)

Section 1. In the case of the removal of the President from office or his death or resignation, the Vice-President shall become President.

Section 2. Whenever there is a vacancy in the office of the Vice-President, the President shall nominate a Vice-President who shall take the office upon confirmation by a majority vote of both houses of Congress.

Section 3. Whenever the President transmits to the President pro tempore of the Senate and the Speaker of the House of Representatives his written declaration that he is unable to discharge the powers and duties of his office, and until he transmits to them a written declaration to the contrary, such powers and duties shall be discharged by the Vice-President as Acting President.

Section 4. Whenever the Vice-President and a majority of either the principal officers of the executive departments or of such other body as Congress may by law provide, transmit to the President pro tempore of the Senate and the Speaker of the House of Representatives their written declaration that the President is unable to discharge the powers and duties of his office, the Vice-President shall immediately assume the powers and duties of his office as Acting President.

Thereafter, when the President transmits to the President pro tempore of the Senate and the Speaker of the House of Representatives his written declaration that no disability exists, he shall resume the powers and duties of his office unless the Vice-President and a majority of either the principal officers of the executive department or of any such body as Congress may by law provide, transmit within four days to the President pro tempore of the Senate and the Speaker of the House of Representatives their written declaration that the President is unable to discharge the powers and duties of his office. Thereupon Congress shall decide the issue, assembling within 48 hours for that purpose if not in session. If the Congress, within 21 days after receipt of the latter written declaration, or, if Congress is not in session, within 21 days after Congress is required to assemble, determines by two-thirds vote of both houses that the President is unable to discharge the powers and duties of his office, the Vice-President shall continue to discharge the same as Acting President; otherwise, the President shall resume the powers and duties of his office.

The 25th Amendment to the Constitution of the United States.

Carrying On When President Cannot: Exhibition Raises Questions About Details in Transfer of Power*

Michael Janofsky

George Washington had a carbuncle. Andrew Jackson had rotting teeth. Chester A. Arthur suffered from a kidney problem known as Bright's disease, John F. Kennedy from a glandular problem known as Addison's disease.

By some accounts, as many as half the men who served as president had an ailment or injury while in office. A new exhibition here at the College of Physicians of Philadelphia, *When the President is the Patient*, traces the historical sweep, from the abscess in Washington's thigh, known then as a carbuncle, to President George Bush's hyperthyroidism.

The exhibition raises serious questions about how much the American public has ever really known about the health of the chief executive and whether proper safeguards are in place to monitor presidential fitness.

Long before ratification in 1967 of the 25th Amendment to the Constitution, which addresses the transfer of power in case of presidential illness or death, experts worried that American policy could be harmed by a bumpy transition or, worse, by a shadow government operating behind a disabled president, as some historians say occurred in the final months of President Woodrow Wilson's second term in 1920.

Organizers of the exhibition, as well as other groups, contend that the 25th Amendment, which has not been invoked for a president's disability, is written so broadly that it would leave too many

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questions open to interpretation, thus risking national stability. Among them are:

- How should the term "unable to discharge the powers and duties of his office," as used in the amendment, be interpreted?
- Who makes the final medical determination that the president is unable to hold office, his personal physician, military medical personnel assigned to the White House, an independent panel or some combination?
- Does the president's doctor owe primary allegiance to the patient or the nation, and how much information about the president's health should the public be given?

"The 25th Amendment needs an operational definition, by statute or regulation," said Dr. Marc S. Micozzi, executive director of the college, where the exhibition will be until next July. "That's the only way we can have a rational process for medical information to be gathered and applied in an objective way."

With its exhibition, the college has become the latest organization to suggest the 25th Amendment needs formal interpretation. A stronger push, however, is likely to come from a panel of 50 historians, politicians, doctors, political scientists, lawyers and journalists, called the "Working Group on Presidential Disability," that began a study of the issue two years ago. The group, which includes current and former White House doctors, plans to make recommendations for change in early December.

Howell Smith, a history professor at Wake Forest University and a member of the group, said that while the group is not expected to endorse amending the 25th Amendment itself, opinions were still divided on several issues. As a result, Professor Smith declined to say what he expected the report to recommend.

Whatever the group's conclusions, the Philadelphia exhibition provides a background for any changes. The presentation relies heavily on copies of portraits and photographs and generic examples of medical tools of the past. But it tells a fairly complete story of presidential afflictions, treatments available at the time and—more critical to contemporary concerns—the degree to which the public was informed and the role of a personal physician.

To explore those issues, the exhibition places added emphasis on Presidents Grover Cleveland and Wilson, whose disabilities were

kept secret, and Franklin D. Roosevelt, who grew far more ill than his personal physician realized.

In 1893, President Cleveland had cancer operations on his jaw two weeks apart on a yacht in Long Island Sound. The procedures were kept secret because Cleveland was pushing to repeal the Sherman Silver Purchase Act of 1890 and his vice-president, Adlai E. Stevenson (grandfather of the later presidential candidate), opposed the repeal. With Cleveland fearing that a sign of poor health would help Stevenson gain support, the White House announced the president was suffering from the extraction of a bad tooth.

After President Wilson suffered a stroke in 1919 while campaigning for American support for the League of Nations, his condition was kept secret by his wife, Edith, his personal physician and a few close aides through the remaining months of his presidency. Not even the vice-president, Thomas R. Marshall, or the Cabinet, knew the extent of his illness. The public, which never saw him again as president, was told he had suffered a nervous breakdown.

President Roosevelt is presented as an example of how a president's personal physician might have hastened death by erring in his diagnosis. After Vice Adm. Ross T. McIntire, an eye, ear, nose and throat specialist, determined that the president was suffering from flu and bronchitis, a cardiologist, Dr. Howard G. Bruenn, found that the president was suffering from hypertension and heart disease.

Less than a month before President Roosevelt won a fourth term in 1944, according to the exhibition, Admiral McIntire pronounced him "perfectly O.K." It is unclear whether Admiral McIntire believed the president's condition had been brought under control after Dr. Bruenn's diagnosis, misunderstood the seriousness of the problem, or was being deceptive.

Five months afer the election, President Roosevelt died.

Opening Remarks Given at the College Forum on Presidential Health

Arlen Specter, U.S. Senator (R-Pa.)

Good morning. I am pleased to have the chance to offer introductory remarks to those attending today's presidential health forum at the College of Physicians of Philadelphia. I am sorry that I cannot be with you personally. I applaud the College leadership for arranging a forum on the extremely important issue of presidential health.

The College of Physicians is an ideal sponsor for a forum on presidential health. The College is the oldest private medical society in the nation. It was founded in 1787, the very year the Constitution was written. One of its founders, Dr. Benjamin Rush, signed the Declaration of Independence. From the beginning, the College has worked to educate both the medical profession and the public about a wide range of public health and public policy issues including the risks associated with alcohol and tobacco use, the importance of good sanitation in homes and neighborhoods, the need to protect the purity of drinking water, and the merit of humane treatment for prisoners. The College's historic work has contributed to numerous laws and regulations designed to protect and enhance public health, including the formation of what has now become the United States Public Health Service. The College has a rich history of contributing to relevant public policy debates.

Today, the College is a medical academy with nearly 2,000 elected members and a nationally-renowned center for the medical humanities. The College draws on its world class historical medical library and medical collections to interpret for the public an historical perspective on contemporary medical issues. Last year the College mounted a major new exhibition called *When the President is the Patient*. This exhibition has received international acclaim and has thrust the College into the position of leading the public discussion on the issue of presidential health.

The College's presidential health exhibit, which I have had the privilege of visiting, raises a number of troubling questions about our system for addressing presidential health issues. How, for instance,

can we strike an appropriate balance between the public's right to know and the president's desire to preserve personal privacy? To what extent can we allow illness to compromise the performance of occupants of the Oval Office? Do presidents receive the best medical care available when they become ill? How can politicians appropriately address the question of presidential disability? And, what is the status of the Twenty-fifth Amendment today?

Some of the questions raised by the College's presidential health exhibit will be addressed during today's forum. Before I discuss these questions, I would like to comment on the status of the Twenty-fifth Amendment and the recommendations of the Working Group on Presidential Disability.

The Twenty-fifth Amendment to the Constitution was ratified in 1967. This amendment represented a serious effort to address the issue of presidential incapacity. It provided procedures for fulfilling the duties of the presidency in the event of the removal, death, or resignation of the president, and for the filling of a vice-presidential vacancy.

Today, the Twenty-fifth Amendment provides the constitutional framework for dealing with questions of presidential succession. The amendment was carefully studied by the Working Group on Presidential Disability. This unofficial committee of academics, lawyers, and others came together several years ago. On December 3, 1996, the Working Group issued a series of recommendations designed to address existing gaps in the Twenty-fifth Amendment.

The Working Group's recommendations include drawing a clear distinction between "impairment" and "disability," increasing the discretionary power of the White House physician, and requiring each new administration to have a medical contingency plan in place before the president-elect is inaugurated. There has been general agreement that, taken together, these recommendations constitute a step forward. Thoughtful critics, however, are concerned that the Working Group's suggestions do not go far enough.

There appears to be little controversy over the Working Group's recommendation to improve the definition of presidential "impairment" and presidential "disability." Significant concern has been expressed about increasing the discretionary power of the White House physician and about White House medical contingency plans. Those who have expressed concern about increasing the discretionary power of the White House physician claim that there exists a potential conflict of interest and an opportunity for the abuse of power because the president is the commander-in-chief and the White House

physician is, traditionally, a military medical officer. Critics of proposals to increase the discretionary power of the White House physician have recommended the establishment of an independent panel of physicians who would provide a mandatory second opinion about a president's mental or physical ability to remain in office.

Medical contingency plans have become an important concern as well. Every administration since President Eisenhower's has had one. Critics of these plans note that the plans are state secrets. This means that they can be changed suddenly to enable a compromised president to remain in office without public disclosure of his or her condition. Critics also remind us that no contingency plan can cover every eventuality.

If members of the Working Group on Presidential Disability had been able to visit the College's exhibition on presidential health before offering their recommendations they would have learned how past presidents—Democrats and Republicans from early to modern times—have participated in efforts to mislead Congress and the American people about the state of their health. They would also have learned how many decisions concerning the ability of an ill or injured president to remain in office have been made on the basis of political rather than medical criteria.

Like the members of the Working Group on Presidential Disability, those attending today's forum are presented with a series of challenging questions about the integrity and quality of our current system of providing for our president's health. To help you understand and address these questions, the College has assembled four distinguished experts on the subject: Dr. George Lundberg, editor of *The Journal of the American Medical Association;* Dr. Herbert Abrams, Professor of Radiology at Stanford University; Dr. Bert Park, a practicing neurosurgeon and author; and Dr. Hugh Evans, Professor of Pediatrics, Preventive Medicine and Community Health at the University of Medicine and Dentistry of New Jersey. Each of these physician-scholars has outstanding credentials and each brings unique knowledge to our public discussion of the issue of presidential health.

As many of you know, I have had the privilege of serving in the United States Senate on the behalf of the citizens of the State of Pennsylvania since 1980. My involvement with the issue of presidential health has spanned my entire public career—from my days on the staff of the Warren Commission to my candidacy for the elected office of the president in 1996. I remain personally and professionally interested in the outcome of today's forum. I am specifically

interested in learning whether the College of Physicians will recommend legislative action to strengthen our current system of providing for the health of the president of the United States.

As you approach the topic of presidential health, I ask you to consider the following questions:

1. Is the public best served by our current system of providing for the president's health?
2. Is the president best served by our current system of providing for presidential health?
3. Under our current system of providing for our presidents' health, can a president deceive the public about the state of his or her health?
4. Would our nation be better served if the White House physician were required to consult with an independent panel of physicians for a mandatory second opinion when it is necessary to make judgements about a president's mental or physical ability to serve in office?

Thank you for providing me with this opportunity to share my views and questions on the important topic of presidential health. I look forward to learning your answers to these and other relevant questions raised by this forum's speakers.

Deception and Presidential Disability: An Historical Analysis

Aaron Seth Kesselheim

Question

Under our current system of providing for the president's health, can a president deceive the public about the state of his or her health?

Introduction

The current system of providing for the president's health provides no safeguards to ensure that the public is kept aware, in a timely and accurate manner, of the state of the president's health. Presidents, along with their hand-selected personal physicians and advisers, hold full control over what, when, and how all relevant medical information relating to presidential illness or injury is made public. An analysis of past presidents' health issues reveals that these men, their physicians, and their advisers have consistently used the mechanisms available to them to mislead the public about the status of their health. The four most significant examples of this tendency in the modern era are Presidents Franklin D. Roosevelt, Dwight D. Eisenhower, John F. Kennedy, and Ronald Reagan. Under these administrations, socially and politically important medical information was covered up through the destruction of records, outright mendacity by physicians and advisers, dissemination of intentionally deceptive and misleading statements, and duplicitous, orchestrated media portrayals. As these examples indicate, under the present system of managing the president's health, not only does the ability exist to cover up relevant information about presidential illness and injury, but that capacity is all-too-often utilized.

Discussion

Franklin D. Roosevelt

President Franklin Roosevelt's death in 1945, at the start of his fourth elected term, was greeted with shock across America—but in reality, to his team of physicians and closest advisers, his death was neither sudden nor unanticipated.[1] From its inception, Roosevelt's presidency was marked with many episodes of illness and infirmity which were successfully hidden from the public in order to present the image of a strong and vigorous leader.[2] These cover-ups were orchestrated by both the president's physicians, who made false and misleading reports to the American people and destroyed medical reports, and the president's close advisers, who organized his public appearances so as to give no hint of his failing health.

The President's Physicians

Roosevelt appointed his personal physician, ENT specialist and Navy Admiral Ross McIntire, in 1932 to combat his persistent head colds and sinusitis.[3] Over the next decade, McIntire grew to guard jealously the prerogatives associated with his office—including a close association with the president, and staunchly supported Roosevelt's policies.[4] As a result, when Roosevelt's health began to fail, McIntire helped orchestrate a significant portion of the medical cover-up of his ill health. By 1941, Roosevelt's health records reveal recordings of progressive diastolic hypertension, lack of oxygen supply to his heart, and iron-deficient anemia.[5] Nonetheless, no public attention was brought to these findings, and McIntire later wrote that Roosevelt's "blood pressure remained on an excellent level . . . and his cardiovascular measurements were within normal standards for a man of his age."[6] By January 1944, a persistent cough, recurrent upper respiratory tract infections, and orthopnea led McIntire to

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[1]Robert E. Gilbert, *The Mortal Presidency: Illness and Anguish in the White House* (New York: Fordham University Press, 1998), 43.
[2]Ibid., 73.
[3]John R. Bumgarner, M.D., *The Health of the Presidents: The 41 United States Presidents Through 1993 from a Physician's Point of View* (North Carolina: McFarland & Company, Inc., 1994), 211.
[4]Ibid., 212.
[5]*The Mortal Presidency*, 53.
[6]Ibid.

order an extensive physical examination from Dr. Howard Bruenn, a lower-ranking naval cardiologist at Bethesda Naval Hospital.[7] Bruenn diagnosed left ventricular congestive heart failure, hypertension, hypertensive cardiomyopathy, and acute bronchitis, and concluded that Roosevelt did not have long to live.[8] However, McIntire ordered Bruenn to report these findings to no one, not even Roosevelt and his family, and Bruenn, bound in part by his code of military discipline to his superior officer, cooperated fully in the conspiracy to misrepresent the president's health status.[9] Instead, McIntire reported to the press that the president had "a moderate degree of arteriosclerosis, although no more than normal for a man his age."[10] When members of the media and Roosevelt's family, concerned with the president's gaunt appearance in June 1944, questioned McIntire about whether Roosevelt should run for a fourth term, he said, "Every possible check-up proved [Roosevelt] organically sound," and predicted that he could "stand up to the strain of four more years."[11] As it turned out, Roosevelt passed away in March of the next year.[12]

In addition to his false public pronouncements, the president's physician actively concealed his patient's medical records. Under McIntire's direction, Roosevelt visited the National Naval Medical Center incognito an astonishing twenty-nine times from 1941 to 1945.[13] Moreover, the most pertinent charts, tests, X-rays, and reports from his health care during this time are missing—a result of McIntire's concern that his optimistic reports to the American public not be refuted.[14]

The President's Advisers

Complicit in Roosevelt's physician's cover-up of the true state of the president's failing health were Roosevelt's aides, who worked to

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[7]Ibid., 55.
[8]*The Health of the Presidents*, 213.
[9]Ibid., 214; Jerrold M. Post, M.D., and Robert S. Robins, *When Illness Strikes the Leader: The Dilemma of the Captive King* (New Haven, Ct.: Yale University Press, 1993), 30.
[10]*The Health of the Presidents*, 215.
[11]*The Mortal Presidency*, 57.
[12]*The Health of the Presidents*, 217.
[13]Kenneth R. Crispell and Carlos F. Gomez, *Hidden Illness in the White House* (Durham, N.C.: Duke University Press, 1988), 117.
[14]Robert H. Ferrell, *Ill-Advised: Presidential Health and Public Trust* (Columbia, Mo.: University of Missouri Press, 1992), 38.

present Roosevelt as a hearty and active leader.[15] From the beginning, the American public never knew that Roosevelt was paralyzed from the waist down as a result of polio in 1921, because media photographs of Roosevelt in his wheelchair were forbidden on threat of the president's secret service seizing the perpetrator's camera and exposing his film.[16] This media management continued as Roosevelt's health deteriorated 1944, as aides screened all photos, allowing "only those least marked by the deadly haggard weariness of the commander."[17] The president's advisers also arranged his public appearances so as to present the false picture of a healthy leader. When rumors swirled during the 1944 presidential race of Roosevelt's ill health, his aides rekindled public confidence in his well-being through open car parades, often in inclement weather.[18] In fact, the president was bolstered by frequent secret stops along the parade route, the surreptitious changing of his clothes, and shots of brandy to quell his pain.[19] Any public appearances cancelled for medical reasons were excused with vague statements of pressing war business, and outside visitors were often banned when the president looked or felt too ill.[20]

The president's advisers even involved the F.B.I. in maintaining the aura of secrecy around Roosevelt's health. When White House Press Secretary Steven Early became concerned as the 1944 election approached that the press's medical reports contained too many specifics and clinical details, he enlisted F.B.I. chief J. Edgar Hoover to investigate the source of the perceived leaks.[21] To further undermine these reports, Early also released glowing reports of the president's health to the press, often enlisting the active approval of Dr. McIntire to maintain that the president's health was "very, very good" and "in splendid shape."

Conclusion

Through a concerted effort by Roosevelt's physician and political advisers to destroy records and promulgate misinformation, the president's early infirmities and later failing health were concealed from the public and even the president himself. As a result of the ease

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[15]*The Mortal Presidency*, 43.
[16]Ibid., 49.
[17]Ibid., 62.
[18]Ibid., 59.
[19]Ibid., 58.
[20]*Hidden Illness in the White House*, 81.
[21]Ibid., 111.

by which presidential illness was covered up, Roosevelt ran for a fourth term of office against rational medical judgement, and the public unknowingly elected a terminally ill and largely incapacitated leader at a crucial post-war point in American history.

Dwight D. Eisenhower

In an effort to boost President Eisenhower's robust image of a healthy war general and vigorous leader, much information was suppressed about the extent and frequency of the cardiovascular and gastrointestinal disease that plagued him throughout his tenure as president.[22] Despite efforts to appear being candid about the president's health, his physicians and advisers conspired to leave some episodes unreported and to use deceptive language deliberately to obfuscate public knowledge of his medical status and under-report the severity of other episodes.

Unreported Illnesses

The president's personal physician, Major General Dr. Howard Snyder, purposefully withheld a number of potentially significant events in Eisenhower's health care from public knowledge. In 1953, Eisenhower had an episode of diaphoresis, chills, nausea, and dizziness which Snyder told the White House press secretary to call "food poisoning," but which appears from its description to have been a myocardial infarction.[23] Snyder was reluctant to reveal the true diagnosis for fear of undermining the confidence in Eisenhower of surviving his first term.[24] Luckily for Snyder, the attack was mild and Eisenhower required no significant recuperation time which may have refuted Snyder's deceptive diagnosis. When Eisenhower had a severe heart attack in 1955, Snyder again labeled it "digestive upset" and delayed announcing the true nature of the episode to the media—one suspects hoping again for a quick recovery so as to not require the revelation of the true medical report.[25]

Another example of unreported presidential illness occurred when a May 1956 physical examination revealed Crohn's disease in

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[22]*The Mortal Presidency*, 74, 104.
[23]*Ill-Advised*, 71.
[24]*The Mortal Presidency*, 85.
[25]*Ill-Advised*, 77.

Eisenhower's ileum.[26] Snyder reported to the press that the president had a "normal functioning digestive tract."[27] However, when the president developed an acute intestinal obstruction in June, 1956, which required surgery, Snyder was forced to come clean with Eisenhower's true diagnosis.[28]

Eisenhower suffered from other critical, unpublicized health crises in his last year of office, ranging from hypertension to upper respiratory tract infections to emphysema, which at times put him in danger of his life.[29] In addition, in November, 1960, Snyder diagnosed "very dangerous" runs of ventricular fibrillation, but again hid these findings from the public.

Deceptively Reported Illnesses

When Eisenhower had his 1955 heart attack, he instructed his advisers that the public should know "everything" about his disease.[30] Instead, Eisenhower's physicians and advisers publicized only the barest essentials of required medical information, and even then did so in the most favorable light possible. Snyder initially diagnosed Eisenhower's 1955 episode as "massive," but reported to the press that the president had a "mild coronary thrombosis."[31] When that position soon seemed too untenable, Snyder upgraded the severity of Eisenhower's condition to "moderate."[32] Moreover, when the ECG showed negative changes a few days later, Snyder and consulting physician Dr. Thomas Mattingly diagnosed an extension of the initial infarction, but told the press that there were "no complications" and had the press secretary report that the president was "a little tired, but otherwise, his condition is good."[33] At press briefing, physicians used distracting tactics, such as long discourses on the pathophysiology of cardiovascular disease, and emphasized unrelated, but seemingly encouraging signs, such as the president's regular bowel habits to distract reporters from questions concerning the actual status of the president or his near-miss with death.[34]

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[26]Ibid., 118.
[27]Ibid.
[28]Ibid.
[29]*The Mortal Presidency*, 114.
[30]Ibid., 91.
[31]Ibid., 89.
[32]Ibid.
[33]Ibid., 90.
[34]*Ill-Advised*, 86.

In the aftermath of Eisenhower's 1956 attack of Crohn's disease, the White House press office was even less forthright with the information they presented to the public, claiming that "ileitis is not something that endangers the president's life."[35] Moreover, when they did discuss the episode with the public, the physicians played the press for fools, not telling the truth about the medical literature on the rate of recurrences and effect of Crohn's disease on a patient's nutritional status, even claiming absurdly, "we think it improves his life expectancy."[36]

A final significant, and deceptively reported, medical event in Eisenhower's tenure was his 1957 stroke, which Snyder initially reported to the press as a "chill," but later changed euphemistically to a "transient ischemic attack."[37] Furthermore, while there was concern among his physicians, most significantly Dr. Mattingly, that this episode was related to the formation of a ventricular aneurysm at the site of his 1955 heart attack, these concerns were never revealed to the public.

Conclusion

In Eisenhower's two terms, the president's personal physicians and advisers clearly embarked on a conspiracy to cover-up the often shaky status of Eisenhower's health by letting significant medical events go unreported and using misleading statements and falsified reports to deceive the public about the severity and consequences of those attacks which were significant enough to require reporting. These efforts helped maintain the robust image of an alert, alive, and vigorous president[38]—a representation often far from the truth.

John F. Kennedy

As with President Eisenhower, the public image of President Kennedy diverged significantly from his true underlying medical status. Though widely recognized as a handsome, virile, and charismatic young leader, Kennedy, along with his physicians and advisers, successfully conspired to hide a potentially very important health issue from public scrutiny—his long-term struggle with Addison's disease.

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[35]*The Mortal Presidency*, 101.
[36]*Ill-Advised*, 122.
[37]*The Mortal Presidency*, 108; *The Health of the Presidents*, 231.
[38]*The Mortal Presidency*, 105.

Addison's Disease

In 1947, Kennedy was diagnosed with Addison's disease, and started a regimen of DOCA and cortisone injection treatments.[39] This disease left him susceptible to infection. In fact, he did suffer quite a number of illnesses prior to his presidency which brought him within threads of his life. The treatment potentially had side effects such as congestive heart failure and mood swings which would be quite significant in the leader of a nation.[40] When the issue of his health status came up during the 1960 campaign, Kennedy first tried to mislead the public, and had his spokesman issue a statement claiming that he did not have Addison's disease "of the classic sort," a narrow medical definition meaning that the disease had not been treated and had entered its final stage.[41] "No one who has the real Addison's disease should run for presidency, and I do not have it," Kennedy said.[42] When a more forceful declaration was needed to satisfy further public queries, his team resorted to even more outright mendacity. His personal physician, Dr. Janet Travell, and another physician, Dr. Eugene Cohen, signed an artfully worded statement claiming that his "adrenal glands do function," and that Kennedy "has not, nor has he ever had . . . Addison's disease."[43]

These statements formed the basis of future misstatements about his health status throughout his presidency.[44] As president, while continuing to deny his condition, Kennedy kept secret stashes of cortisone replacement treatments in safety deposit boxes around the country in the case of a sudden attack.[45] He also engaged in secret treatments with Dr. Max Jacobson, a New York physician who injected Kennedy with large doses of corticosteroids laced with amphetamines—all out of the public eye.[46] This veil of secrecy survived even after his assassination, as Rear Admiral Dr. George Burkley endorsed an autopsy report that made no mention of his condition.[47]

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[39]*The Health of the Presidents*, 240.
[40]Ibid.; *The Mortal Presidency*, 165.
[41]*Ill-Advised*, 152.
[42]Ibid.
[43]*The Health of the Presidents*, 243; *The Mortal Presidency*, 163.
[44]*Hidden Illness in the White House*, 196.
[45]Bert E. Park, M.D., *Ailing, Aging, Addicted: Studies of Compromised Leadership* (Lexington, Ky.: The University Press of Kentucky, 1993), 170.
[46]Ibid., 171.
[47]*Ill-Advised*, 156.

Conclusion

Kennedy's medical status was covered up in other arenas as well—for example, the public never knew of the numerous, repetitive novocaine injections Dr. Travell administered for his back pain, and after his assassination, access to his medical information was denied, leaving the rampant speculation about his death that persists even to this day.[48] Thus, through the same mechanisms as Presidents Roosevelt and Eisenhower before him, Kennedy, his advisers, and physicians successfully conspired to conceal important aspects of the president's health from public scrutiny and debate.

Ronald Reagan

The most significant recent time that the president, his physicians, and his advisers have employed the current system of providing for the president's health to misrepresent his medical condition occurred during the Reagan administration. President Reagan suffered through two life-threatening medical emergencies during his tenure, a 1981 assassination attempt and a 1985 surgery to treat colon cancer.[49] In both of these instances, the presidential inner circle employed misleading medical reports and media management to present a deceptively optimistic public picture of Reagan's health.

Surviving and Recovering from an Assassination Attempt

After John Hinckley shot President Reagan on March 30, 1981, Reagan arrived at the hospital in shock, with severe blood loss and a collapsed lung.[50] Early information promulgated by the president's press sources was erroneous and incomplete, and some initial reports even claimed him to be "not seriously injured."[51] Later, after the president's situation stabilized, presidential physician Dr. Daniel Ruge met with the White House political liaison to come up with a plan on how to disseminate information about Reagan's condition.[52] Though later reports more accurately depicted the critical situation Reagan was in, like reports of other presidential medical

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[48]*The Health of the Presidents*, 244, 246.
[49]*The Mortal Presidency*, 210.
[50]*The Health of the Presidents*, 282.
[51]Ibid.
[52]*The Mortal Presidency*, 223.

crises, the positive aspects were accentuated, and the reports revealed none of the physicians' concerns at the various stages of Reagan's recovery.[53]

Throughout the nearly six months of recovery time that followed Reagan's shooting, medical access was tightly controlled, from the substance of the reports given to the media to the fact that, to the detriment of prudence and safety, no outside medical consultants were brought in to evaluate Reagan's condition.[54] The news regularly featured clips of a vigorous and alert president, but these shots were carefully screened, revealing only the brief and unrepresentative intervals of lucidity and vigor in the president's significant disability.[55]

Colon Cancer

After his assassination, the next major medical crisis to befall Reagan was the discovery and removal of a cancerous polyp in his ascending colon in 1984.[56] Once again, the White House tightly controlled the flow of information concerning the president's recovery from surgery and long-term prognosis.[57] Physicians were made inaccessible to the media, photos were only allowed in specially arranged settings and poses, and Nancy Reagan informed the president's spokesman that he was not to use the words "cancer" or "masses" in his briefings.[58] Reagan himself helped orchestrate this veil of secrecy, announcing the policy that the White House was to release only that information it felt the news media absolutely had to know.[59]

Other Health-Related Issues

Evasiveness and misrepresentations marked two other, less serious, instances in which Reagan's health came in question. Just a few short weeks after his colon cancer surgery, the presidential physicians removed a basal cell carcinoma from Reagan's nose.[60] However, the White House announced that Reagan suffered from "irritated skin," in order to avoid using the word "cancer" so close to Reagan's re-

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[53]Ibid.
[54]Ibid., 228.
[55]*When Illness Strikes the Leader*, 12.
[56]*The Mortal Presidency*, 233.
[57]Ibid., 237.
[58]Ibid.; *The Health of the Presidents*, 284.
[59]*The Mortal Presidency*, 237.
[60]Ibid., 239.

covery from colon cancer, even though basal cell carcinoma is a non-invasive form of skin cancer.[61] Under intense questioning and criticism, however, the White House changed its position a week later, announcing the true pathology of Reagan's condition.[62]

Finally, Reagan underwent prostate surgery in 1987.[63] As with Reagan's more serious medical crises, the White House tightly controlled the flow of all information through the press secretary, and Reagan's advisers sent the surgeons back to the Mayo Clinic in Minnesota without allowing the press to ask them questions regarding Reagan's condition.[64]

Conclusion

Reagan's bouts with assassination attempts, colon cancer, skin cancer, and prostate surgery reveal that even as recently as ten to fifteen years ago, the procedures for managing the president's health give the president, his physicians, and his advisers the ability to cover up the president's medical status.

Conclusion

As experiences with presidential illness and injury from Presidents Roosevelt to Reagan indicate, significant latitude exists under the present system of managing presidential health for internal cover-ups of significant medical problems. Implicated in these conspiracies to conceal presidential disability are a wide variety of sources, from the president himself, to the president's family, his advisers, his secret service and the F.B.I., and even—and often especially—the personal and consulting physicians assigned to care for the president. Moreover, many different mechanisms have been employed in the intentionally deceptive portrayals of presidential health, including destruction of records, falsifying of reports, use of purposefully vague or misleading descriptions, management of media images, and outright public untruthfulness. That conspiracies featuring the same people and mechanisms have reappeared numerous times over the

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[61]Ibid.
[62]Ibid.
[63]*Ill-Advised*, 158.
[64]Ibid.

years reveals not only the ease by which the White House can deceive the public about the state of the president's health, but its strong inclination to do so when the opportunity arises.

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Resuscitating the Twenty-Fifth Amendment: Mandating a Second Opinion for the Determination of Presidential Disability

Bert E. Park, M.D.

Presidential scholars have debated the reasons behind Woodrow Wilson's refusal to compromise in order to obtain congressional approval of the Versailles Peace Treaty at the end of World War I.[1] A reevaluation of the president's medical record clearly demonstrates that poor health was at least partially responsible for this outcome. Available records, particularly volumes 58 through 65 of *The Papers of Woodrow Wilson*, confirm that Wilson's thought processes and public conduct were adversely affected by progressively severe hypertension, culminating with the major stroke he suffered in 1919.[2] Recently released material supports earlier suggestions that the pervasive impact of his neurological deterioration made Wilson unable to adequately fend for himself or his cause.[3]

Wilson's impairment can be divided into two stages. For roughly twenty years up to and including his speaking tour in September 1919, Wilson experienced the insidious onset of heart, kidney, and brain dysfunction as a result of longstanding hypertension. After his hypertension-related stroke in early October 1919, the president's health declined precipitously. Few could deny that his mental faculties and comportment had changed significantly.

The transformation was, to some extent, predictable. Once untreated hypertension reaches an accelerated or "malignant" phase,

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[1]John Morton Blum, *Woodrow Wilson and the Politics of Morality* (Boston: Little, Brown, and Co., 1956) and Alexander and Juliette George, *Woodrow Wilson and Colonel House* (New York: Dover Publications, 1965).

[2]Arthur S. Link, ed., *The Papers of Woodrow Wilson* (Princeton: Princeton University Press, 1966–1992), particularly volumes 58–64. Hereafter abbreviated as *WWP*.

[3]Bert E. Park, *The Impact of Illness on World Leaders* (Philadelphia: University of Pennsylvania Press, 1986), pp. 3–76 and Appendix, pp. 331–342; Edwin A. Weinstein, *Woodrow Wilson: A Medical and Psychological Biography* (Princeton: Princeton University Press, 1981).

damage to blood vessels leads to retinal hemorrhages, heart failure, renal insufficiency, and cerebral vascular accidents. A full six years before Wilson assumed office, his ophthalmologist had already documented the effects of uncontrolled hypertension. It is not surprising that thirteen additional years without treatment led to catastrophic brain injury in 1919.

Neuropsychologists would probably have identified a reduction in Wilson's "adaptive versatility" by 1918. Persons with this deficiency generally manifest a low threshold of frustration. They are prone to making unwarranted criticisms and faulty judgements and frequently complain of tiring easily. Unable to adapt to rapidly changing circumstances, they tend to concentrate on one issue at a time in order to reduce their mistakes. At the same time, they lose the ability to pay attention to details. As their emotions become less restrained, they become impervious to advice and insensitive to the concerns of others. Wilson exhibited virtually all of these characteristics by the spring of 1919 prior to his western tour.

During the accelerated phase of such cognitive decline, affected persons often become pathologic caricatures of their former selves. It is now recognized that individuals, like Wilson, who begin with more rigid adaptive patterns often exhibit greater impairment over time. For these reasons, Wilson's character and inner conflicts remain essential to understanding his behavior at the end of World War I.

Wilson's final stroke, however, was an equally important if controversial component of his presidency. It was once assumed that limited medical knowledge during the first quarter of this century precluded a precise diagnosis. This view is no longer tenable. It is now clear that the president was medically impaired and that his physician and closest associates did not acknowledge the ramifications of his disability. As a consequence, this contributed to the Senate's ultimate rejection of the Versailles Treaty and sealed the fate of the League of Nations.

The story of Wilson's presidency is a cautionary tale, to be sure, and one that most Americans continue to ignore at their own peril.[4] Despite the subsequent passage of a constitutional amendment designed to expedite both voluntary and involuntary certification of presidential disability, the haunting specter of illness in the Oval Office has not been adequately addressed. Five years before the ratification of the Twenty-fifth Amendment in 1967, President John F.

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[4]Arthur S. Link, "Woodrow Wilson: A Cautionary Tale," *Wake Forest Law Review* 30 (Fall 1995), pp. 585–592.

Kennedy governed under the influence of steroids and amphetamines.[5] Ronald Reagan was medically impaired and, arguably, constitutionally disabled on three separate occasions during his presidency, although the public was never aware of this and no formal declaration was made.[6]

Recently, two independent groups re-examined the Twenty-fifth Amendment with particular attention to Section 4, which addresses the case of a president who cannot or will not recognize his own disability.[7] The absence of medical testimony during the congressional hearings that preceded the final drafts of the amendments lead to the conclusion that the current formulation was adequate, although certain deficiencies in implementation were recognized. Both groups eventually recommended an increase in the discretionary powers of the presidential physician and continued reliance on secret contingency plans. Skeptical observers, however, recognize that these recommendations permit administrations to maintain internal control over the process of declaring a president disabled. Moreover, the current protocol for recognizing presidential disability remains seriously flawed. How, for instance, can a contingency plan provide for every eventuality? What is to prevent an impaired president from altering the plan when a threat to his or her political survival emerges? Can the president's physician be dismissed, so that no one is left to monitor an afflicted president's health? Can both the public interest and the president's be adequately protected when there is no requirement for expert consultation in the event of presidential illness or injury? Would expert consultation not serve to support the presidential physician who finds him or herself in the unenviable position of whistle-blower?

Those who are satisfied with the current system fear that changes such as required consultations with outside experts or publicly articulated contingency plans would make the presidency more, not less, vulnerable. They argue that disclosure of pertinent medical

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[5]Bert E. Park, *Ailing, Aging, Addicted: Studies of Compromised Leadership* (Louisville: University Press of Kentucky, 1993), pp. 168–186.

[6]Bert E. Park, *Ailing, Aging, Addicted: Studies of Compromised Leadership* (Louisville: University Press of Kentucky, 1993, pp. 209–210; Herbert L. Abrams, "*The President Has Been Shot*" (New York: W. W. Norton and Co., 1992), pp. 37–38.

[7]White Burkett Miller Center of Public Affairs at the University of Virginia and University Press of America, *Report of the Miller Center Commission on Presidential Disability and the Twenty-fifth Amendment* (1988) and *Transactions of the Working Group on Disability in U.S. Presidents*, Carter Center, Atlanta, GA, January 26–28, 1995 and Wake Forest University, Winston-Salem, November 10–12, 1995.

conditions may affect a president's performance. Such health information could be amplified by the media and become a powerful if unwarranted pawn in political power games. Opponents of reform also conjure up fear of an ineffectual "medicine by committee" which might predominate if additional consultation was mandatory. Unfortunately, the jealousy with which White House insiders guard access to the president makes it unlikely that they will invite outside consultation, if not required to do so.

Acceptance of the Miller Commission and the Wake Forest recommendations ignores the frightening legacy of past experience. To begin with, one in three presidents have become seriously disabled or died while in office. Moreover, as Wilson and Roosevelt stories' indicate, disability needs to be evaluated by the best available expertise. Finally, the American public has a right to know how disability will be determined. The complexity of these issues calls for a formal, institutionalized process for evaluating presidential disability. Unfortunately, the nation may need to confront a new crisis, an assassination, or a natural illness before the importance of a revised approach becomes painfully apparent. Recent candidates and the current president have recognized the public's right to know that their leader is not impaired or disabled. They have even accepted the need for independent medical corroboration of the state of the president's health.[8] More than one presidential physician, however, has indicated that they regard the participation of colleagues as an onerous oversight rather than an opportunity for complementary, supportive, and necessary assistance. Practical means of reconciling these disparate concerns is needed before the next crisis forces our hand. It is in this spirit that the following recommendations are offered:

1. Establish an Office of the Physician to the President through a joint or concurrent resolution of Congress, and strengthen this Office by inclusion of a prospectively designated team of medical consultants.
2. The organization of the Office should follow the team approach, as this structure remains one of the more successful innovations of contemporary medical practice. In keeping with this model,

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[8]Comments of former President Jimmy Carter to the Working Group on Disability in U.S. Presidents, Carter Center, Atlanta, January 28, 1995; Interview with Robert Dole, *Washington Post*; remarks of Bill Clinton as cited in the *Transactions of the Working Group on Disability in U.S. Presidents*, Carter Center, Atlanta, GA, January 26–28, 1995 and Wake Forest University, Winston-Salem, November 10–12, 1995.

the president's physician should not only be a member of the team, but should also direct it medically and "chair" it in an administrative and a legal sense.

3. In order to establish as efficient and cohesive a team as possible, the president and the presidential physician should make the final choices from a list of nominees submitted by the American Medical Association.
4. The president's physician must, however, reserve the right to call in additional specialists of his or her choosing to assist the team.
5. The consulting body should not have the authority to report its medical findings to the public under any circumstances, but only to the vice-president and cabinet. If disagreement about a president's perceived disability persists, then the consultants could speak before a public legislative hearing, as Section Four of the Twenty-fifth Amendment already grants Congress twenty-one days to assess the president's disability in the case of disagreement between the vice-president and the cabinet.
6. The president and his or her physician will have taken oaths to uphold the Constitution. As a result, their allegiance to that document must take precedence over their relationship as commander and subordinate, not to mention as physician and patient. The president's physician would be required to disclose the consulting team's findings to the vice-president and cabinet even if commanded to conceal them by the Chief-of-State/First Patient.
7. Mandating full disclosure of the medical records of presidential candidates to the public is neither necessary nor desirable. Confidentiality could be maintained by requiring candidates and their physicians to sign affidavits asserting that they are not aware of any medical conditions that could be expected to impact adversely on the individual's ability to perform the duties of the office. The receipt of federal campaign funds could become contingent on submission of such affidavits.

Ideally, any future determination of presidential inability would entail two distinct and separate steps: first, defining the degree of physical or mental impairment that is present and second, assessing whether that impairment is adversely affecting the president's occupational duties enough to be termed a "disability."[9]

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[9]See in particular the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (4th Edition 1993).

The Miller Center Commission called for a meeting between Election Day and the inauguration "to devise plans for all medical contingencies."[10] This recommendation was followed by the Bush administration in 1989. In reality, these hypothetical contingencies are molded by political concerns regarding which medical problems warrant invoking the Twenty-fifth Amendment, who should provide the medical evaluation, and what information should remain confidential.

As our past history demonstrates, simply increasing the responsibility of the president's physician will not be adequate. Take for example, his or her role in evaluating mental or psychological compromise. Although everyone agrees that an impaired president should not resume office until functional restoration has been certified, few are aware of the factors that limit this process. Historically, the presidential physician has had little expertise in this area of medical practice. Neurologists or psychiatrists selected after a condition develops are not only unfamiliar with the president's health until that time, but are also beholden to the administration which selected them. Their ability to arrive at informed and unbiased judgement might be severely compromised.

The option of reconstructing the Twenty-fifth Amendment altogether, either with a new amendment or by statute, has been rejected by several parties. One constitutional scholar has already declared that there is "an insufficient historical track record to justify revision of the amendment."[11] Nor should anyone underestimate the difficulty of negotiating the inevitable legislative minefield. Former President Jimmy Carter alluded to these difficulties when he offered a solution of his own:

> Not only the president's physician, but his entire cabinet, can be dismissed in a moment. The president's physician, no matter how independent he or she might be, needs to have the backing of a consultative group that might be delineated by law. Let that group, with the president's physician as a spokesperson, make a mandatory report to the cabinet and the vice-president.[12]

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[10]Feerick, *Twenty-Fifth Amendment*, xxvi.
[11]Feerick, *Twenty-Fifth Amendment*, xxviii.
[12]Comments of former President Jimmy Carter, *Transactions of the Working Group on Disability in U.S. Presidents*, Carter Center, Atlanta, GA, January 26–28, 1995.

Proponents of the current system claim that medical specialists are available at a moment's notice to evaluate the president if the need arises. The public, however, needs to know how these specialists are selected. Are they the best in their fields, or merely the most visible? What is their personal relationship with the presidential physician, and what political ties might they have to the administration as a whole.

A bicameral congressional resolution could mandate the prospective selection of a group of consultants skilled in the determination of impairment. This group would then be empowered to pass judgement on the president's state of health along with the presidential physician. Only after they have arrived at their conclusions would the constitutionally designated instruments of the executive branch (the vice-president and the cabinet), or if necessary the legislative branch (Congress), be summoned to assess the effect of the president's health as stipulated in the Twenty-fifth Amendment.

This group of bi-partisan consulting specialists would be selected or appointed before an incoming administration is inaugurated. It should be charged with monitoring the president's health on a yearly basis and convening on an emergency basis if the question of inability arises. These physicians would not have the power to initiate disability proceedings against the president, much less the power to depose him. Their duties would be restricted to gathering medical facts impartially and to assisting the vice-president and cabinet in arriving at an informed decision. As such, the panel of consultants would only function as an advisory body. There would be no avenues by which these unelected persons could wrongfully usurp authority.

As impairment that affects cognitive function and, hence, decision making is the most threatening, the consulting team should include at least two neurologists, two internists with expertise in hypertension and cardiopulmonary pathology, and two psychiatrists. The seventh member would be the presidential physician. That doctor would be able to provide an overview of the president's health but would also be able to provide a deciding vote in the unlikely case of a deadlock. Either the Institute of Medicine or the American Medical Association would be appropriate bodies for nominating prospective team members before a presidential election. The nominees' credentials could then be examined in a public forum such as open hearings before House and Senate committees. The presidential physician and the incoming president would then select a team from the list of nominees.

These physicians would not be responsible for the daily care of the president, other than as consultants. They would, however, participate in his or her yearly physical evaluation for the purpose of establishing a point of reference from which they could detect subtle changes in the president's condition.

In reality, specific guidelines for evaluating impairment and consequent disability are already well established, making the above proposal all the more appealing. For almost twenty-five years, physicians have accepted the American Medical Association's *Guides to the Evaluation of Permanent Impairment* as the standard by which impairment is objectively and uniformly determined.[13] The A.M.A.'s *Guides* underscore the important distinction between the terms "impairment" and "disability," and clarify who should make those determinations.[14] Clinical studies have shown that the A.M.A.'s *Guides* for determining impairment and disability have worked well when applied to executives of major corporations.[15] It would be reasonable to extend these successful guidelines to the assessment of presidential disability as covered by the Twenty-fifth Amendment.

The identification of impairment by an independent panel of consultants would also clarify the potential risks associated with a certain level of impairment, thereby assisting the vice-president in determining whether the president is able to resume his or her official duties. The vice-president would have access to non-partisan medical information in order to decide whether an impairment is adversely affecting the performance of the president's duties enough to be regarded as a disability covered by the Twenty-fifth Amendment to the Constitution.

The election of any president is, barring malfeasance in office or disability, a four-year contract. If the consultants identified an impairment that was likely to extend beyond the remainder of the president's term, the vice-president and cabinet would be able to prevent any resumption of power by the president until or unless the disabled president improved. This, of course, assumes that the vice-president and cabinet will have subsequently determined that the president's

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[13]American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th Edition, 1993).

[14]American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th Edition, 1993).

[15]David S. Glass and Miriam G. Wardle, "Reliability and Validity of the American Medical Association's Guides to Ratings of Permanent Impairment," *J.A.M.A* 248 (1982), pp. 2292–2296.

capacity to meet his occupational demands is being limited by that impairment.[16]

While medical consultants can assess the risks of allowing an impaired individual to continue in his or her present employment, it is neither their right nor duty to determine the acceptability of those risks. That assessment rests on non-medical considerations and should be made by the vice-president and the cabinet. The dilemma faced by Woodrow Wilson's associates following his stroke illustrates the dangers inherent in allowing presidential physicians to let their own opinions of non-medical issues influence what should be strictly medical judgements.[17]

Some constitutional scholars, however, would have us believe that presidential inability is strictly a policy matter based on political circumstances.[18] Yet whether a vice-president would perform more capably than his disabled superior is not the salient issue. What is important is an expeditious and unbiased gathering of facts that would warrant initiating disability proceedings in the first place. The Constitution currently allows elected or appointed officials to pass judgement without mandated, impartial, medical expertise. This risks putting the political cart in front of a questionably impaired horse.

Therein lies the real problem: with or without supplementary contingency plans the Twenty-fifth Amendment does not explicitly require medical consultation.[19] Consultation is, of course, suggested but only during the eleventh hour after disagreement over the presence of presidential impairment has emerged. In recognition of the need for prompt resolution of such controversy, the Constitution currently allows the cabinet and the vice-president four days to review the data and make a determination. If disagreement persists, then the vice-president retains the powers and duties of the office, while Congress considers the matter. Congress is required to produce a decision within twenty-one days.[20] In order to expedite the determination during the first four days and avert the pitfalls of the longer process, a prospectively selected panel of independent medical consultants

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[16]For a definition of the terms impairment, disability, and handicap see American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th Edition, 1993), p. 2.

[17]Bert E. Park, *The Impact of Illness*, pp. 63, 282; *Ailing, Aging, and Addicted*, pp. 110–111; Dr. Grayson's comments cited in *WWP* 64: pp. 507–513.

[18]Ruth D. Silva, *Presidential Succession* (New York: Greenwood Press, 1968), p. 92.

[19]*U.S. Constitution*, Amendment xxv, section 4.

[20]*U.S. Constitution*, Amendment xxv, section 4.

already familiar with the president's health must be included in the process.

Section 4 of the Twenty-fifth Amendment also fails to address the very real possibility that an impaired president might dismiss cabinet members who threaten to depose him before the situation reaches a crisis level. History has already shown that President Wilson was able to engage in such maneuvers.[21] That is why any team of consultants must be more closely linked to the vice-president than to the cabinet, as only the former cannot be forced by the president to resign. That said, even though the cabinet might be willing to declare a president disabled, a squeamish vice-president might choose to abstain. As a result, a disabled president could remain in office. Such an impasse actually occurred following the attempted assassination of President Reagan in 1981.[22] If, however, a team of consulting physicians presented information to the vice-president before the four-day deadline passed, he or she might be more inclined to act decisively.

It would be naïve to think that Congress could act swiftly in the event of disagreement between the cabinet and the vice-president. Moreover, a president could veto any statute that threatened his political survival. For this reason, concurrent congressional resolutions must prospectively define the procedural issues involved in assessing presidential impairment. Hastily assembling specialists after the fact, and only after disagreement has emerged, risks directing medical opinion along partisan lines. Such an ad hoc approach would also further delay disability proceedings, simply because the pertinent medical data are not readily available.

Despite the obvious need for improving the management of presidential disability, there will be objections to a panel for assessing presidential impairment or disability. In addition to voicing concern over expanding bureaucracy, critics point out that similar proposals have already been evaluated and dismissed. The proposal under consideration, however, differs substantially from its predecessors. For one thing, previous panels were not prospectively selected, nor did they have a comparable composition. Nor were earlier proposals designed to function within the guidelines outlined by the Twenty-fifth Amendment. In order to appreciate the merit of the current suggestion, it is necessary to review its origins.

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[21]Park, *Impact of Illness*, p. 53; *Ailing, Aged, Addicted*, p. 114; "Editorial," *Philadelphia Evening Public Ledger*, 2/11/1920 in *WWP* 65: 6.

[22]"Twentieth Century Task Force on the Vice Presidency: A Heartbeat Away," (1988); Abrams, "*The President Has Been Shot*," pp. 98–99.

Dwight D. Eisenhower's brush with death in 1955 brought the limitations of Article II of the Constitution concerning presidential disability into sharp focus.[23] Confronted with suggestions for a "Presidential Disability Commission," Attorney General Herbert S. Brownell quickly dismissed any proposal that would establish "formal legal machinery" requiring physical and mental examinations during an inquest into alleged presidential disability. Brownell argued that putting the president's health "constantly on trial" would be "an affront to (his) personal dignity and degrade the office itself."[24] This narrow view ignored the evidence of past cases where the nation's best interest would have been better served had the president's health been under closer medical scrutiny. In addition, Brownell's position would question, by analogy, the Federal Aviation Administration's requirement that pilots undergo independent annual medical evaluations in order to continue flying.

Brownell also warned that the deliberations of a disability commission might drag on for weeks. Worse yet, it could be undertaken in a political forum that would give rise to conflicting testimony and divide public opinion.[25] Neither argument remained valid after the ratification of the Twenty-fifth Amendment. Not only are the vice-president and the cabinet required to arrive at an opinion in four days, but Congress must act within twenty-one. Moreover, any deliberations of the medical consultants would be undertaken in secret. Their findings would only be made public after a basis for declaring the president impaired had been firmly established.

Testifying before the Senate in 1958, Charles S. Rhyne, then president of the American Bar Association, unwittingly exposed the crux of the problem while attempting to downplay the need for such a panel or commission. Rhyne noted that "historically, the real problem of presidential inability has not stemmed from a question of determining the existence of any presidential inability. . . . The inability usually has been clear and undisputed."[26] Yet providing for the unusual is precisely why a prospectively chosen, non-parti-

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[23]*U.S. Constitution*, article II, section 1, clause 6.

[24]Herbert S. Brownell, U.S. Attorney General, opinion cited in *Special Subcommittee on Study of Presidential Inability of the House Committee on the Judiciary*, 85th Congress, First Session, 26 (1957).

[25]Herbert S. Brownell, U.S. Attorney General, opinion cited in *Special Subcommittee on Study of Presidential Inability of the House Committee on the Judiciary*, 85th Congress, First Session, 26 (1957).

[26]Presidential Inability: Hearings Before the Senate Judiciary Sub-Committee on Constitutional Amendments, 85th Congress, 2nd Session, 194 (1958).

san team of medical experts is necessary. Consider the subtleties involved with the determination of neurological impairment in recent presidents. How significant was the impact of large quantities of steroids and amphetamines on the thought processes of President John F. Kennedy?[27] How much did Ronald Reagan's performance after surgery in 1981 and 1985 reflect lingering post-anesthetic and narcotic effects, enhanced by his age?[28] What degree of cognitive impairment did Reagan manifest during his last term as he moved toward his current diagnosis of Alzheimer's disease?[29] These troubling questions involve borderline cases of inability that no vice-president, cabinet member, White House staff member, or even presidential physician would prudently assess alone.

Despite these glaring shortcomings, this is how matters have stood since the ratification of the Twenty-fifth Amendment in 1967. Since any determination of presidential disability begins with the identification of physical or mental impairment, it has been very unfortunate that the role of the presidential physician has been rarely mentioned in Senate or House committee hearings. This absence is one reason why the Miller Center and Wake Forest study groups independently recommended greater involvement on the part of the presidential physician. These groups, however, limited their recommendations to reinforcing the Twenty-fifth Amendment and supporting secret contingency plans in case presidential inability occurred. Their unenforceable suggestions that the president's physician should be consulted and given more discretionary power, and that the White House staff "should not try to govern by itself, [but should] deal with the public in an open and honest manner," were primarily a confirmation of the existing approach with its evident limitations.[30] In reality, the implementation of any process to certify presidential disability has relied not so much on the presidential physician as on the willingness of the president's staff to invoke something as serious as the Twenty-fifth Amendment when they deem it necessary.

Undoubtedly, political considerations often dictate against invoking the Twenty-fifth Amendment. Yet consider the cynic's view

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[27]Park, *Ailing, Aging, Addicted*, pp. 168–186.
[28]Park, *Ailing, Aging, Addicted*, pp. 216–218.
[29]Bettina Boxall and Deborah Schoch, "Reagan Says He Is In Early Stages of Alzheimer's," *Los Angeles Times*, November 6, 1994.
[30]*Transactions of the Working Group on Disability in U.S. Presidents*, Carter Center, Atlanta, GA, January 26–28, 1995 and Wake Forest University, Winston-Salem, November, 10–12, 1995 as quoted in Feerick, *The Twenty-fifth Amendment*, xxi.

for the moment. Under the present arrangement, can we be certain that even the most conscientious presidential physician will be able to recognize the occurrence of subtle impairment? How do we combat the inherent tendency among staff members to ride out the storm during what might be perceived as a temporary illness? And what of those with an authoritarian bent—the Haigs, Reagans, and Bakers of the future—who will presume to call the shots in the president's absence? Regardless of the pecking order that evolves (or the contingency plan in place), the involved parties will probably attempt to make the best of a bad situation by presenting a unified and optimistic front to the media. A president's inner circle is geared to respond pragmatically to any crisis that presents itself. Yet the president's unanticipated absence, particularly if it entails a serious illness whose duration is uncertain, presents its share of problems. Not only do staff appointees lack the necessary expertise to judge the seriousness or duration of their superior's disability, but they also have no constitutional mandate guiding their actions.

Despite the troubling nature of the historical record, some critics remain opposed to the involvement of independent, prospectively selected physicians. Spokespersons for the media argue that they could not help but expose the deliberations of any such committee.[31] In reality, members of a medical team functioning as consultants would have professional and ethical obligations regarding confidentiality. No revelations would be forthcoming unless impairment affecting the performance of presidential duties had been identified and agreed upon.

A panel of consultants should not be dismissed because it resembles "medicine by committee," any more than the input of consultants should be rejected in the care general patients. Furthermore, President Jimmy Carter and at least one recent presidential physician have publicly supported a team approach, both for providing care and for determining any physical or mental impairment that could result in a subsequent disability.[32]

Finally, the suggestion that presidential disability could be arbitrarily determined by a close vote ignores the traditional and vital role consultants play. The very fact that medical experts other than the presidential physician have examined the pertinent data and

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[31]Thomas Wicker, remarks at Working Group, Atlanta, January 28, 1995.

[32]Jimmy Carter and Larry Mohr, respectively, remarks at Working Group, Atlanta, January 28, 1995.

produced a collective opinion (including a "minority" report if necessary) will at least insure that the matter has been given careful scrutiny. In the final analysis, the American public cannot afford to leave such delicate medical judgements to the presidential physician alone, much less to White House legal advisors, staff appointees or similar personnel.

The Twenty-fifth Amendment does not provide adequate definitions of terms such as "inability" and "unable." While such ambiguity may be in keeping with the general style of the Constitution, it serves little purpose now that these terms have been clarified and precise definitions have been accepted by doctors, insurance companies, judges, and employers. Moreover, simply relying on prearranged contingency plans to specify when the amendment should be invoked not only risks failing to provide for all eventualities; such contingency plans might prove to be too binding and narrowly tailored.[33]

There remains, then, a compelling need to be more specific with regard to what presidential impairment is and who determines it. Any measure which is ultimately adopted, however, must not be so specific as to define disability within a political context or attempt to identify all contingencies in advance. The first step in this process, rather, should be the passage of a concurrent resolution by Congress that designates the composition of a consulting body and specifies the method and prospective timing of its selection. Not only will such medical expertise strengthen the position of the presidential physician, it will finally provide for that necessary "second opinion" the American public deserves.

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[33]Freerick, *Twenty-Fifth Amendment*, xxiii.

Final Report of the College's Presidential Health Task Force

William L. Kissick, M.D., M.P.H., Chair, and Aaron Seth Kesselheim

From 1997 to 1998, the College of Physicians of Philadelphia held an exhibit, *When the President is the Patient*, along with a series of related lectures. As part of this project, on November 19, 1997, the College sponsored a forum on *Presidential Disability and the 25th Amendment*. Senator Arlen Specter, who gave the opening remarks, charged the forum to consider the following questions:

1. Is the public best served by our current system of providing for the president's health?

The current system of providing for the president's health provides no safeguards to ensure that the public is kept aware, in a timely and accurate manner, of the state of the president's health. The public's ability to rely on the medical information released by the White House can have great significance in the selection of and confidence in the governing power of the president.

As an illustration, in 1944, terminally ill President Franklin D. Roosevelt was elected for a fourth term by an American public that was oblivious to his infirmity. There are reports that the president's health status affected his performance and stature among his allies at the close of World War II. For example, his liberal concessions to Stalin at the Yalta Conference are postulated by some as being related to his poor stamina. It is not known whether, given the full range of information, the American people might have voted for a different leader to close the war and lead America's post-war transition.

2. Is the president best served by our current system of providing for the president's health?

Because, under the current system, most of the discussions about the health of the president are done behind closed doors, the president's

physicians are often subject to increased political pressures that may lead them to act against their patient's best interests.

For example, President Roosevelt's cardiologist diagnosed him with congestive heart failure, hypertension, and hypertensive cardiomyopathy in early 1944. However, President Roosevelt's personal physician and his close advisers, believing in the ultimate importance of Roosevelt leading the country through the War, kept this terminal prognosis secret even from Roosevelt and his family. Instead, Roosevelt (and the public) was told that he was healthy enough to endure four more years in office. As a direct result, against sound medical judgement, Roosevelt ran for a fourth term in the fall, and, partly due to the continued strain from the political process, he passed away in March 1945.

As another example, President John F. Kennedy underwent secret hormone treatments for his Addison's disease from a New York physician, Dr. Max Jacobson. Jacobson injected him with massive doses of corticosteroids laced with amphetamines, a form of treatment not in concert with the contemporary medical recommendations regarding the care of Addison's disease. Still, because of the clandestine nature of these treatments, it is not clear whether the full risks and benefits, or the general appropriateness, of these injections was ever discussed with him. Kennedy also received repetitive novocaine injections for his back pain from his personal physician. Again, since his condition was shrouded in secrecy, it is not clear whether Kennedy had a chance to consider his full range of options and the notion that mainstream medical opinion questioned the efficacy of this therapeutic regimen.

3. Under our current system of providing for our president's health, can a president deceive the public about the state of his or her health?

Presidents—along with their hand-selected personal physicians and advisers—have held full control over what, when, and how all relevant medical information relating to presidential illness or injury is made public. As a result, socially and politically important medical information can be covered up through the destruction of records, outright mendacity by physicians and advisers, dissemination of intentionally deceptive and misleading statements, and duplicitous, orchestrated media portrayals.

President Roosevelt was often so ill during his 1944 campaign that his aides would artificially prop him up during parades. Despite

much medical evidence to the contrary, his personal physicians continued to give his general health exemplary public reports. Behind those words, however, the FBI was once called in to ferret out the source of leaks about the president's ill health, and his personal physician had all his medical records destroyed.

When President Dwight D. Eisenhower suffered his 1955 heart attack, it was diagnosed as "massive," but divulged to the public as "mild" and later "moderate." EKG reports showed extension of the infarction, but Eisenhower's physician reported "no complications." At press conferences, the physicians and aides deliberately misled the press by focusing on positive, unrelated events and giving long discourses on the pathophysiology of cardiovascular disease.

Kennedy, as a Presidential candidate, had his personal physicians sign a deceptive, artfully worded statement denying that he suffered from Addison's disease. The veil of secrecy surrounding his battle with this ailment persisted throughout his presidency and even up to his assassination, when his autopsy report purposefully left out mention of his condition.

During both of President Ronald Reagan's major medical crises—his 1981 assassination attempt and later colon cancer surgery—his inner circle employed misleading medical reports and media management to present a deceptively optimistic public picture of Reagan's health. In 1981, all reports to the press were overly optimistic, and none relayed any of the president's physicians' concerns at the various stages of his recovery. When Reagan faced colon cancer, his policy was to release only that information the media "absolutely had to know." Physicians were made unavailable to the media and photo opportunities were arranged only during his strongest hours.

4. Would our nation be better served if the White House physician were required to consult with an independent panel of physicians for a mandatory second opinion when it is necessary to make judgements about a president's mental or physical ability to serve in office?

Experiences with presidential illness and injury indicate that significant latitude exists under the present system of managing presidential health for internal cover-ups of medical problems. Implicated in these conspiracies to conceal presidential disability are a wide variety of sources, from the president himself, to the president's family, his advisers, his secret service and the FBI, and even—and often

especially—the personal and consulting physicians assigned to care for the president. History has made clear the inclination of the White House to keep secret the state of the president's health, as well as the harmful effects this practice can have on both the president and the public. An independent panel of physicians could not only ensure that the president's treatment decisions are made in his or her personal best interest, but also that the public can have confidence in the medical information received from the White House.

In response to Senator Specter's four questions, the College appointed a "Committee on the 25th Amendment," chaired by William L. Kissick, M.D., Dr.P.H., George Seckel Pepper Professor of Public Health and Preventive Medicine, University of Pennsylvania. The Committee is comprised of six other outstanding Philadelphia-area physicians:

- Dr. George Ross Fisher, M.D., trustee and delegate to the American Medical Association
- Dr. Charles T. Lee, Jr., M.D., President of the College
- Dr. Marc S. Micozzi, M.D., Ph.D., Executive Director of the College
- Dr. Jonathan E. Rhoads, M.D., John Rhea Barton Professor of Surgery, Emeritus, University of Pennsylvania, and former Director of the Board of Regents of the American College of Surgery
- Dr. Brooke Roberts, M.D., Professor of Surgery, Emeritus, University of Pennsylvania
- Dr. Albert J. Stunkard, M.D., Professor of Psychiatry, University of Pennsylvania

After deliberating over this issue, the Committee felt that the current system of providing for the health care of the president of the United States has in the past failed to serve effectively the president himself and the public, and has even been exploited as a means of deceiving the public about the state of the president's health. Moreover, the health care received by the president of the United States serves as a model for the country as a whole, and so should be invested with the same high caliber, flexibility, privacy, and other qualities expected of the American people in their own health management. As a result, the Committee proposes that an Act of Congress create a physician panel to provide a second opinion to the White House physician under the authority of ". . . or of such other body as Congress may by law provide . . ." of Section 4 of the 25th Amendment.

Draft Bill Prepared by the Committee

___ Congress, ___ Session S/H.R. _____

In the _____ of the United States
_____ __, 200_

Mr./Ms. _____ introduced the following bill, which was read twice and referred to the committee on the judiciary.

A BILL

To amend the _____ to define section 4 of Amendment XXV to the Constitution, ". . . or of such other body as Congress may by law provide . . .", as a consultative panel of physicians to the White House physician.

PURPOSES

The current system of providing for the health care of the president of the United States must serve effectively the president himself and the public, and should not be exploited as a means of deceiving the public about the state of the president's health. Moreover, the health care received by the president of the United States acts as a model for the country as a whole, and so should be invested with the same high caliber, flexibility, privacy, and other qualities expected of the American people in their own health management.

DEFINITIONS

(a) Establishment: There is established a consultative panel of physicians charged with assisting the physician of the president of the United States to ensure that the president receives the highest quality of medical care (the "Panel").

(b) Duties of the Panel: The Panel shall . . .

(1.) Annually review the health care provided to the president in a manner that preserves the general standards of patient confidentiality.
(2.) Be called upon to review the general medical care of the president, whenever the White House physician should feel it indicated to seek consultation.
(3.) Be called upon to review promptly the president's health care during medical crises.

(4.) Report their findings soon thereafter to the appropriate political body as established under the 25th Amendment.
(5.) Make recommendations to the appropriate political body as necessary concerning the management of the president's health and his medical capacity to serve his office faithfully.
(6.) Upon the president's leaving office, report to the appropriate professional organizations and the public concerning the quality and effectiveness of the care received by the president during his preceding term of office.

(c) Membership:

(1.) Number and appointment: The Panel shall be composed of at least six members, of whom . . .

(A) One shall be appointed by the president of the American Medical Association;
(B) One shall be appointed by the president of the American College of Physicians–American Society of Internal Medicine;
(C) One shall be appointed by the president of the American Academy of Family Physicians;
(D) One shall be appointed by the president of the American College of Surgeons;
(E) One shall be appointed by the president of the American Academy of Neurology;
(F) One shall be appointed by the president of the American Psychiatric Association;
(G) One shall be appointed by the president of the American Association of Cardiologists;
(H) If the president is female, another member shall be appointed by the president of the American College of Obstetrics and Gynecology for the term of her presidency;
(I) If the incoming president has any significant existing medical conditions, the presidents of the appropriate professional bodies from those medical specialties shall also each appoint a member for that president's term of office.

(2.) All Panel members will be professionally qualified in their respective fields and appropriately chosen.

(3.) The presidents of these medical associations shall be prevented from appointing themselves.
(4.) Congress shall ratify all appointments.

(d) Chairman: The members of the Panel shall select their own chairman.

(e) Further consultation: The Panel shall consult with outside physicians as needed to optimize the president's health care.

(f) Terms of appointment: In the initial creation of the Panel, two members shall be appointed for two years, three members for four years, and two members for six years. Thereafter, the term of all replacement appointments under paragraph (1) to the Panel shall be four years.

(g) Meetings: The Panel shall meet and exercise their duties under the conditions enumerated in paragraph (b).

(h) Vacancies: A vacancy on the Panel shall be filled in the same manner in which the original appointment was made not later than 30 days after notice of the vacancy is given. The new member shall be appointed only for the remaining term of the member he or she is replacing.

(i) Compensation: Members of the Panel shall receive the specified DHSS per diem by reason of their service on the Panel and reimbursement for any needed travel expenses.

(j) Staff: The Panel shall be staffed and budgeted through the Institute of Medicine.

The Vice-President's Condition: A Wake-Up Call To Congress

William L. Kissick, M.D., Dr.P.H.
and Marc S. Micozzi, M.D., Ph.D.,

John Adams was a man who spoke his mind. As the nation's first vice-president, Adams came to view the job as a personal humiliation, denouncing the post as "the most insignificant office ever conceived by the mind of man." The authority that Vice-President Cheney commands today might inspire Adams. Mr. Cheney is on track to becoming the most powerful vice-president in U.S. history. Due to his continuing health concerns, he has become influential in another way, by focusing public attention on the impact of medical disability in office. The implications are serious and the historical record is not encouraging, as documented in our permanent exhibit at the College of Physicians of Philadelphia. George Washington and fully half of the men who followed him suffered a serious illness while in office. (Washington nearly died twice.) Ill health has inspired more White House cover-ups than sexual and financial misconduct combined.

American presidents have generally wanted to remain in office as long as the Constitution, and voters, would allow. Several ill presidents, abetted by their aides and physicians, deceived both Congress and the voters to keep their jobs. In 1893, Grover Cleveland endured a secret operation aboard a yacht on the high seas so that a tumor could be removed secretly. Following a stroke in 1919, Woodrow Wilson virtually disappeared for the final 18 months of his presidency. Later he admitted, "it would probably have been better if I had died last fall." While it is unlikely that such episodes would be repeated today, other scenarios remain. After President Eisenhower suffered a heart attack in 1955, Press Secretary Jim Hagerty obscured the severity of the illness by drowning the media in medical detail. Following the shooting of President Reagan in 1981, his condition was much more serious than the public understood.

We also like to believe that our presidents get the best medical care available. This assumption has often proven false. Once inside the White House, political considerations can trump medical

concerns. After President Eisenhower's heart attack, the head of his medical team believed that he should not seek a second term, but was persuaded to sign a statement saying that Eisenhower was healthy enough to run again. In 1944, a dying FDR was re-elected to an unprecedented fourth term. Sometimes, simple incompetence was responsible for substandard care. Both FDR's physician and the doctor treating Warren Harding were oblivious to their patients' obvious signs of heart disease. Furthermore, the White House physician is often a military doctor called upon to resolve conflicts between the Hippocratic Oath and the oath to uphold and defend the U.S. Constitution in caring for the Commander-in-Chief. When an ordinary patient gets medical care, physicians follow a standard protocol. The pressures and conflicts which surround the president can make it difficult to go by the book.

Four years after the assassination of President Kennedy, the 25th Amendment to the Constitution was ratified. The amendment provides a framework through which a seriously impaired Chief Executive can be removed from office. This article, which has never been tested, is problematic. The existing framework allows appointed cabinet members to determine whether an impaired president should remain in office, while the president retains the power to dismiss subordinates he has appointed.

The amendment also explicitly anticipates that Congress legislate a body to help make an inherently political process more medically objective. This could be accomplished by an independent panel of physicians (perhaps chaired by the U.S. Surgeon General who has a statutory appointment and cannot be dismissed by the president), to render a critical second opinion. In most cases, this body would work quietly, beneath the radar screen. In remarkable circumstances, it would help make a decision about whether an impaired president should remain in office. This would provide a constitutional protection whose time has come.

When the President is the Patient

Exhibition Catalogue

Introduction

America is currently engaged in a global war against terrorism. The diplomatic, economic, military, and political complexities of this international effort are challenging. This first war of the 21st century reminds us how important it is that the president of the United States enjoy the good health and vitality necessary to be a focused and effective commander-in-chief. While this conflict is different from any other war our nation has fought, questions from past wars still echo in our collective consciousness. If President Woodrow Wilson had not been disabled by a massive stroke during the climactic battle over the League of Nations Treaty in 1919, might the U.S. have entered the League and helped to prevent World War II? If President Franklin D. Roosevelt had not been dying during the World War II Yalta Conference, could the parameters of the Cold War have been very different? As a practical people, Americans embrace the rationality, rigor and rules of scientific research, but remain haunted by historical questions for which there are no definitive answers.

As the nation's first medical academy, the College of Physicians of Philadelphia believes that the lessons of history are too important to be left with historians alone. Students of the presidency need to be more aware of the frequency and impact of health problems in the White House. Too often, this dimension is missing from their analyses. While some scholars may know that fully half of our presidents have been seriously ill while in office, the American people do not. In 1996, the College became the first cultural institution to mount a major exhibition designed to provide a comprehensive account of that history. *When the President is the Patient* contributed to our understanding that troubling constitutional, medical and political issues remain unresolved to this day.

This catalogue reproduces the entire script of the original exhibit, and includes illustrations that present these abstract concepts as images of the health challenges confronting one individual. This catalogue will be of interest to the public and to scholars a century from now.

Marc S. Micozzi, M.D., Ph.D.
Executive Director

The College's exhibit on presidential health opened in 1996.
Courtesy College of Physicians of Philadelphia

When the President is the Patient

Former First Lady Edith Wilson feared that history would repeat itself. Twenty-four years after leaving the White House, she returned to mark the beginning of President Franklin D. Roosevelt's fourth term. Noting the president's appearance, Mrs. Wilson told Secretary of Labor Frances Perkins that "he looks exactly as my husband did when he went into his decline." "Don't say that to another soul," responded Secretary Perkins, "he has a great and terrible job to do and he's got to do it even if it kills him." In three months it did.

When the president of the United States is seriously ill, no response is without potential consequences. Such an event may spark tremors on Wall Street, uncertainty within NATO, and unwelcome attention from the nation's enemies.

Today, managing a president's health is not just a medical challenge, but a delicate public relations issue. Since President Dwight D. Eisenhower's heart attack in 1955, television has been both an observer of and a participant in the health crises of our presidents.

As the presidential election of 1996 passes into history, some critical issues remain undecided:

- What specific steps might be taken to certify the health of those who would be president?
- Do our presidents actually get the best medical care available?
- Since the 25th Amendment has never been tested, how do we know it will work?

Alexander Graham Bell Searches For The Bullet That Struck President Garfield
Reproduced from Stefan Lorant, *The Glorious Burden* (1977)

President Johnson Undergoes Gall Bladder Surgery
Courtesy of Yoichi R. Okamoto, LBJ Library Collection

Early Presidents & Their Illnesses

Of our first ten presidents, George Washington, Andrew Jackson, William Henry Harrison, and Zachary Taylor were all war heroes. For each of these men, valor on the field of battle virtually assured their election. Washington commanded the American army that won the American Revolution; Jackson defeated the British at the Battle of New Orleans in the War at 1812; Harrison in 1811 defeated the Shawnee Indians at the Battle of Tippecanoe; and Taylor won key victories in the War with Mexico.

Each of these early presidents also brought a history of illness to the White House. Like many American soldiers of the time, Washington, Jackson, Harrison, and Taylor were exposed to various diseases, including dysentery, malaria, and yellow fever. All of these presidents suffered health problems during their administrations. Harrison and Taylor died in office, Washington almost did, and Jackson was in pain almost every day. Few Americans at the time, however, knew just how sick their presidents were.

George Washington (1789–1797)

Andrew Jackson (1829–1837)

William Henry Harrison (4 March–4 April 1841)

Zachary Taylor (1849–1850)

George Washington
Portrait by Gilbert Stuart
1797
Copyrighted by the White House Historical Association

Our first president almost died of pneumonia in 1790, his second year in office. He was so ill that Secretary of State Thomas Jefferson wrote to a friend that "We have been very near losing the President." Though his doctors thought he would die, Washington did recover and completed two terms in office.

Samuel Bard, M.D.
Engraving by W. Main
date unknown

Wax Model of a Carbuncle
By Joseph Towne, London
ca. 1850

In March 1789, a few months after taking office, Washington was seized by a high fever and violent pains as a result of a "malignant carbuncle," or a large abscess on his left thigh. Dr. Bard, a prominent New York City physician, saved the president's life by draining the carbuncle by incision. This model shows what Washington's carbuncle may have looked like.

John Jones, M.D.
Silhouette by unknown artist
date unknown

In 1790, Dr. Jones of Philadelphia was called by Dr. Bard to help in treating President Washington's pneumonia. The first professor of surgery at King's College and a co-founder of the New York Hospital and the College of Physicians of Philadelphia, Dr. Jones wrote the first American textbook on surgery (1775).

James Craik and Elisha Cullen Dick
Silhouette by unknown artist
date unknown
Reproduced from Wyndham B. Blanton, *Medicine in Virginia in the Eighteenth Century* (1931)

Dr. Craik, chief physician and surgeon of the American army during the Revolutionary War, was Washington's personal physician before he became president. Dr. Dick, who practiced medicine in Alexandria, Virginia, was one of the physicians consulted by Dr. Craik in 1799 during Washington's last illness.

G. Washington in His Last Illness Attended by Doctors Craik and Brown
Etching by unknown artist
1800
Courtesy of the New-York Historical Society

In December 1799, former President Washington came down with a severe cold and sore throat. As Washington's condition declined, Doctor Craik called on fellow physicians Dick and Gustavus Brown for help. Washington's doctors bled, blistered, and purged him. He did not respond to the treatment and died on 14 December. Although the treatment of Washington was later condemned as hastening his death, it was in keeping with the accepted medical practices of the time.

Andrew Jackson
Portrait by Ralph Eleaser Whiteside Earl
1836–1837
Courtesy of the National Museum of American Art, Smithsonian Institution
Transfer from the U.S. District Court for the District of Columbia

When he was inaugurated as our seventh president, the 62 year old, rail-thin Andrew Jackson was described by one observer as "a tottering scarecrow in deadly agony." The new president was in pain emotionally as well as physically. Not only had he just lost his wife to a heart attack, but he was suffering from rotting teeth, chronic headaches, failing eyesight, and constant pain and internal bleeding from two bullets lodged in his body.

Andrew Jackson Shortly Before His Death
Daguerreotype attributed to Edward Anthony
1845
Courtesy of the Mead Art Museum, Amherst College. Gift of William Macbeth Gallery.

Known for his hot temper and thin skin, Jackson was shot in two separate duels, in 1806 and 1813. The bullet Jackson re-

ceived in the earlier duel lodged near his lung, causing repeated attacks of internal infection and bleeding. In the 1813 duel, Jackson took a bullet in the left shoulder, causing him much pain for the rest of his life. It is considered remarkable that he lived through his two terms in office.

Philip Syng Physick
Portrait by Albert Rosenthal after Thomas Sully
1916

As the result of the two bullet wounds, Jackson's health problems became progressively worse during his second term in office. In pain almost every day, the president in June 1833 consulted the eminent Philadelphia surgeon, Dr. Physick, for the bleeding in his lungs. Dr. Physick, who recommended bloodletting, provided no relief to the ailing president.

William Henry Harrison
Daguerreotype by Southworth and Hawes
date unknown
Courtesy of The Metropolitan Museum of Art

One of only two Whig party candidates elected to the presidency, William Henry Harrison was at age 68, the oldest person to reach that office until Ronald Reagan was elected almost a century and a half later.

Presidential Inauguration of William Henry Harrison
Lithograph attributed to Charles Fenderich
1841
Courtesy of the Portrait File, Miriam and Ira D. Wallach Division of Art, Prints, and Photographs, The New York Public Library, Astor, Lenox and Tilden Foundations

Due to his age, Harrison faced election rumors that he was unwell. To discredit these rumors, Harrison waged a very active campaign that left him exhausted. Although the day of his inauguration was bitterly cold, the new president wore neither an overcoat nor a hat. His inaugural address lasted almost two hours. He developed a severe chest cold, from which he never fully recovered.

Death of Harrison
Lithograph by Henry R. Robinson
1841
Courtesy of the National Portrait Gallery, Smithsonian Institute

Two weeks after his inauguration, Harrison, weakened from a lingering chest cold, took an early morning walk and got caught in a rain storm. The new president developed pneumonia. Harrison's physician bled and purged him, but to no avail. Harrison died on 4 April, one month after taking office.

Memorial Armband
1841
Courtesy of the Library of Congress

William Henry Harrison was the first president of the United States to die in office. Many Americans mourned his death by wearing armbands like this one.

John Tyler
Daguerreotype attributed to J. M. Edwards and E. Anthony
date unknown
Courtesy of the Chicago Historical Society

John Tyler of Virginia was the first American vice president to assume the presidency as a result of the death of a president.

The Inauguration of Zachary Taylor
Engraving by Bightly and Keyser
1849
Reproduced from Stefan Lorant, *The Glorious Burden* (1977)

General Zachary Taylor was 64 years old when he became the 12th president of the United States. He was given the nickname

"Old Rough and Ready" by his fellow soldiers.

President Zachary Taylor
Daguerreotype
date unknown
Courtesy of the Library of Congress

In August 1849, during a trip through the northeastern United States, Taylor was bedridden with a violent attack of diarrhea and high fever. His personal physician feared that the president would not recover. "Old Rough and Ready" did and returned to Washington. A year later, Taylor faced a similar attack, but this time it proved fatal.

Death of General Zachary Taylor
Lithograph by Nathaniel Currier
1850
Courtesy of the National Portrait Gallery, Smithsonian Institution

The Fourth of July 1850 was a blistering hot day in Washington, D.C. President Taylor celebrated the day by standing and sitting bare-headed in the sun for several hours. He then took a long walk along the Potomac River. Upon returning to the White House, the president drank large amounts of cold water and chilled milk, and ate fruit. That evening Taylor became sick. He was diagnosed as having "cholera morbus," a term for intestinal ailments. His condition declined over the next two days, and a regimen of calomel (mercury) and opium did little to relieve him. Neither did blisters, bleeding, and purging. After suffering through four days of sharp abdominal pains, diarrhea, and vomiting, the president died.

Zachary Taylor Memorial Ribbon
1850
Courtesy of the National Museum of American History, Smithsonian Institution

On 6 July President Taylor predicted that "In two days I shall be a dead man." He died on the 8th, the second president to die in office. Millard Fillmore, Taylor's vice-president, served out his term.

"The President Has Been Shot"

Five times during our nation's history, Americans have been stunned by the news that their president had been shot. Many Americans can recall where they were "the day Kennedy was shot." The picture of a wounded President Reagan being pushed into the back seat of the White House limousine reminded many of us how vulnerable our presidents are to would-be assassins.

Presidents Abraham Lincoln, James A. Garfield, William McKinley, and John F. Kennedy were killed by assassins' bullets. Questions have been raised by historians about the quality of medical care received by these presidents after they were shot. Criticisms of the management of Garfield's and McKinley's cases, for example, arose almost immediately. Whether these presidents could have been saved with better medical care is an issue that is still being debated by historians and physicians.

Andrew Jackson (1829–1837)

Abraham Lincoln (1861–1865)

James Abram Garfield (1881)

William McKinley (1897–1901)

John Fitzgerald Kennedy (1961–1963)
and
Ronald Wilson Reagan (1981–1989)

Assassination Attempt of President Andrew Jackson
Lithograph by George Endicot
date unknown
Courtesy of the Library of Congress

On 30 January 1835 President Andrew Jackson went to the Capitol to attend the funeral of Congressman Warren Davis of Mississippi. When the president walked

along the Capitol's east portico after the service, he was approached by an unemployed house painter named Richard Lawrence. When Lawrence was within eight feet of the president, he drew a pistol and attempted to shoot Jackson. The pistol misfired. Lawrence then drew a second pistol, which also misfired. The ever-feisty Jackson raised his walking stick and went after his assailant, who was arrested and later declared insane. The first assassination attempt of an American president had failed.

President Abraham Lincoln
Photograph by Alexander Gardner
1865
Courtesy of the Library of Congress

This photograph, taken on 10 April 1865, shows a president wearied by the Civil War. Four days later, President Lincoln was assassinated.

Assassination of President Lincoln
Engraving by unknown artist
1865
Reproduced from Stefan Lorant, *The Glorious Burden* (1977)

Exterior View of Ford's Theater
Photograph
date unknown
Courtesy of the Library of Congress

Presidential Box at Ford's Theater
Photograph
1865
Courtesy of the Library of Congress

On the evening of 14 April 1865 President Lincoln and First Lady Mary Todd Lincoln attended Washington's Ford's Theater to see the comedy "Our American Cousin." Shortly before 10:30 that evening, John Wilkes Booth, an actor and a southern sympathizer, entered the presidential box and shot Lincoln in the back of the head with a derringer. Two Army doctors rushed to the wounded Lincoln and tried to revive him with artificial respiration and brandy. Once the president's breathing was restored, he was moved to a nearby boarding house.

Nelaton Probe
ca. 1860

After the president was carried to the boarding house, a number of government officials and physicians arrived on the scene. The doctors used a probe similar to this one to locate the bullet. The bullet traveled about seven inches into Lincoln's brain and lodged behind his left eye. The physicians felt that there was nothing they could do to save the president.

President Lincoln's Blood-Stained Collar
Courtesy of Professor D. Gary Lattimer, The Queen's University Medical School

It has since been questioned whether Lincoln could have been saved if the physicians on the scene had decided to operate, and had removed the bullet. Even if the doctors had modern techniques of surgery available, it would not have made a difference. The bullet had caused a severe hemorrhage and damaged vital brain tissue. This blood-stained collar was removed from the president's shirt after his death.

The Death of President Lincoln
Engraving by an unknown artist for *Harper's Weekly*
1865
Reproduced from Stefan Lorant, *The Glorious Burden* (1977)

Lincoln died at 7:22 A.M. on 15 April. He was the first American president to be killed by an assassin's bullet. Vice-President Andrew Johnson took over Lincoln's duties as Chief Executive.

President James A. Garfield
Photograph by Matthew Brady
date unknown
Courtesy of the Library of Congress

On 2 July 1881, two months after he was sworn in as the 20th president of the United States, James Abram Garfield was shot in Washington's Baltimore and Potomac railroad station as he was boarding a train for Williamstown, Massachusetts. Garfield was the second American president to die by assassination. Vice-President Chester Alan Arthur took over as president.

Assassination of President Garfield
Lithograph by W. T. Mathews
1881
Courtesy of the Library of Congress

Garfield was shot by Charles J. Guiteau, a mentally disturbed, unsuccessful office seeker. He was struck by two bullets from Guiteau's English bulldog .44 caliber pistol. One bullet grazed the president's right arm. The second bullet entered the right side of Garfield's back, breaking a rib, piercing the spine (but not the spinal cord) and lodging within inches of the backbone below the pancreas. As he was shot, the president cried out "My God! What is this?"

Surgeons in Charge of President Garfield
Drawings by unknown artist
1881
Reproduced from William Ralston Balch, *Life of President Garfield* (1881)

The wounded Garfield was moved to the White House, where he was placed under the care of a team of prominent physicians. The team was directed by Dr. D. Willard Bliss (top). Dr. Bliss and other members of the team inspected the wound with their fingers and a long silver probe to determine the track and location of the bullet. The doctors decided not to remove the bullet, believing the attempt would kill Garfield.

David Hayes Agnew
Portrait by Bernard Uhle
1889

Dr. Agnew was one of the members of the impressive medical team assembled to manage the case of President Garfield. At the time, Dr. Agnew was a professor of surgery at the University of Pennsylvania. A leading American surgeon, Dr. Agnew served as the president of the American Surgical Association and of the College of Physicians of Philadelphia.

Diagram of Bullet Wound
Drawing by unknown artist
date unknown
Reproduced from Robert Reyburn, *Clinical History of the Case of President James A. Garfield* (1894)

Chart of Temperature, Pulse and Respiration of President Garfield
Chart of Robert Reyburn
2 July–19 September 1881
Reproduced from Robert Reyburn, *Clinical History of the Case of President James A. Garfield* (1894)

Bistoury Used in the Operation upon President Garfield August 8th, 1881
Courtesy of the National Museum of Health and Medicine, Washington, D.C.

At first, Dr. Bliss believed that Garfield would not survive the first night. As it turned out, the president lingered for 80 days. As Garfield seemingly recovered, Dr. Bliss and the other doctors closely watched his breathing, pulse, and temperature. They also drained the wound and incised any abscesses that developed. The bistoury, owned by Dr. Bliss, was probably used in one of these procedures.

Alexander Graham Bell Searches for the Bullet
Engraving by unknown artist
date unknown
Reproduced from Stefan Lorant, *The Glorious Burden* (1977)

During the weeks following the assassination of Garfield, his physicians made numerous unsuccessful attempts to locate the

bullet. Alexander Graham Bell tried out his new electromagnetic induction balance, but he too failed.

President Garfield Dying in the White House
Lithograph by W. A. Rogers
1881
Courtesy of the Library of Congress

Garfield was moved from the White House in early September to his summer home in Elberon, New Jersey to escape the capital's intense heat and humidity. The change seemed to help at first, but whatever hopes the doctors had of the president's recovery were dashed. Garfield's splenic artery burst, which caused internal hemorrhaging. He died on 19 September. Garfield's doctors were criticized for hastening his death by introducing infection into the wound because of their probing with unwashed fingers and instruments.

William McKinley, "Our Next President"
Hand-Colored Photograph
1896
Courtesy of Thomas A. Horrocks

On 6 September 1901 William McKinley, 25th president of the United States, was shot while visiting the Pan American Exposition in Buffalo, New York. The president died eight days later. Vice-President Theodore Roosevelt assumed McKinley's presidential duties. This photograph shows McKinley in June 1896, before he was elected president.

President McKinley's Last Speech
Photograph
1901
Reproduced from the *Buffalo Medical Journal*, Vol. 41 (1901)

McKinley delivered this speech on 5 September, the day before he was assassinated.

Assassination of President McKinley
Drawing by T. Dart Walker
1901
Reproduced from Alexander K. McClure and Charles Morris, *The Authentic Life of William McKinley* (1901)

On 6 September McKinley was standing in a receiving line in the Pan American Exposition's Temple of Music, when he was approached by a mentally deranged man named Leon Czolgosz. The assassin had hidden a .32 caliber revolver under a handkerchief wrapped around his hand. He fired two shots and McKinley crumpled to the ground. In severe shock, the president was moved to the small Exposition Hospital.

Chart of Pulse, Temperature and Respiration of President McKinley
Photographic reproduction of chart
1901
Reproduced from the *Journal of the American Medical Association*, Vol. 37 (1901)

Diagrams Showing the Course of the Two Bullets
Sketch by Dr. Edward Wallace Lee
1901
Courtesy of the Buffalo and Erie County Historical Society

Notes Made by Dr. Nelson W. Wilson During Surgery on President McKinley
Manuscript
1901
Courtesy of the Buffalo and Erie County Historical Society

The first physicians to arrive on the scene decided to remove the bullet. Dr. Roswell Park, the most qualified local surgeon, was out of town, so Dr. Matthew Mann, another leading surgeon who specialized in gynecology, was chosen to operate. The Exposition Hospital was ill-equipped for such an operation, but Dr. Mann and his three assistants decided to proceed be-

cause they feared that McKinley was bleeding internally. This drawing by Dr. Edward Wallace, who assisted Dr. Mann, shows the course of each bullet. Another assistant, Dr. Nelson Wilson, made rough notes of the operation.

Mr. Matthew D. Mann
Photograph by J. N. Matthews
1901
Reproduced from the *Buffalo Medical Journal*, Vol. 41 (1901)

Instruments Used in the Operation on President McKinley
Photographic reproduction
date unknown
Courtesy of the Buffalo and Erie County Hospital Society

The lighting in the hospital was inadequate. One of the physicians used a hand mirror to reflect the rays of the setting sun into the president's opened stomach. Dr. Mann was unable to find the bullet and decided to give up the search. After his assistants repaired the tears in McKinley's stomach and cleaned out the wounds, Dr. Mann closed the incision. He did not drain the wound.

President McKinley's Casket Arriving in Canton, Ohio
Photograph
1901
Courtesy of the Library of Congress

After the operation McKinley was moved to the home of the Exposition's president, where he seemed to get better. The president's doctors thought he had a fair chance of recovering. Early news bulletins to the American people were optimistic enough to convince Vice-President Roosevelt to leave town for a vacation in the Adirondacks. On the 13th, however, the president's condition began to deteriorate. McKinley died in the early morning hours of 14 September.

Scrapbook of Dr. Matthew D. Mann
Scrapbook
Courtesy of the Buffalo and Erie County Historical Society

Dr. Mann created a scrapbook of newspaper clippings on McKinley's assassination. Dr. Mann and his assistants, like President Garfield's doctors years before, were criticized for their handling of McKinley's case. Dr. Mann's decision not to drain the president's wound was questioned by many of his colleagues. While the autopsy was inconclusive concerning the cause of death, Dr. Mann's decision may have played a significant role in the president's demise.

President Kennedy Slumps Over after Being Hit by an Assassin's Bullet in Dallas, Texas
Photograph
22 November 1963
Courtesy of UPI/CORBIS-BETTMANN

No assassination of an American president, except that of Abraham Lincoln, has caused so much controversy as that of President John F. Kennedy's on 22 November 1963. The American people were at first shocked and later mourned the death of the young and popular president. A commission appointed to investigate the events surrounding the assassination in Dallas, Texas, reported that Kennedy was killed by a lone gunman, Lee Harvey Oswald. The commission's report has been questioned by many since its release in 1964. Numerous conspiracy theories have been advanced in the wake of Kennedy's death. Few would argue, however, that Kennedy could have survived the massive head wounds inflicted by the two bullets.

President Reagan Is Shoved into the Presidential Limousine after Being Shot
Photograph
1981
Courtesy of AP/Wide World

On 30 March 1981, two months after he was inaugurated as the 40th president of the United States, Ronald Reagan was shot by John Hinckley, Jr. after giving a speech at the Washington Hilton. Hinckley fired a number of shots and one hit Reagan in the chest. The president was rushed to George Washington Hospital, where he underwent three hours of surgery to remove the bullet that had entered his lung. While Reagan's wound appeared to be more serious than those suffered earlier by Presidents Garfield and McKinley, he survived the surgery and made a good recovery.

Deception, Disclosure & The Politics of Health

Over the past century the health of our presidents has become a political as well as a medical issue. Beginning with Chester Alan Arthur's administration in 1881, the perceived political consequences of disclosing a president's medical problems have sometimes conflicted with the public's concern for accountability and openness. Presidents Arthur and John F. Kennedy chose to keep their incurable diseases secret. President Dwight D. Eisenhower, on the other hand, advocated full disclosure. President Lyndon B. Johnson chose at first not to disclose information about his gallbladder problem. He later changed his mind, even showing reporters the scar left from his surgery.

The cases of Presidents Grover Cleveland, Woodrow Wilson, and Franklin D. Roosevelt, covered in detail elsewhere in this exhibit, are perhaps the most famous examples of the nondisclosure of health problems.

Chester Alan Arthur (1881–1885)
Warren Gamaliel Harding (1921–1923)
Dwight David Eisenhower (1953–1961)
John Fitzgerald Kennedy (1961–1963)
Lyndon Baines Johnson (1963–1969)

Chester A. Arthur
Portrait by Daniel Huntington
1885
Copyrighted by the White House Historical Association

Neither the American people nor Chester Alan Arthur knew that he was a sick man when he became the nation's 21st president. In 1882, various people close to the president noticed that he was becoming increasingly depressed, irritable, and lethargic. A cousin described Arthur as "sick in body and soul." Sometime during that year, the president was diagnosed as suffering from Bright's disease. Few of Arthur's friends ever knew. The American people did not discover Arthur's secret until 1911.

Title Page of Richard Bright's Reports of Medical Cases Selected With a View of Illustrating the Symptoms and Cure of Diseases by a Reference to Morbid Anatomy (London, 1827)

Bright's disease was at the time an incurable kidney disorder discovered by London physician Richard Bright in 1811. Arthur's staff kept the news secret. When the *New York Herald* reported that the president had Bright's disease, it was denied by the administration as "pure fiction." The American public never knew that the president was so ill in 1883 that he nearly died while on a trip to Florida. Knowing that he would never survive a second term in office, Arthur did little to seek the Republican nomination in 1884. He died in 1886.

Warren Gamaliel Harding
Portrait by Edmund Hodgson Smart
1923
Copyrighted by the White House Historical Association

When they elected Warren Harding the 29th president of the United States, the

American people did not realize that they were replacing one sick Chief Executive with another. Harding undoubtedly looked healthier than his predecessor, Woodrow Wilson, who had suffered a debilitating stroke. Yet Harding was not a well man: he was suffering from high blood pressure and heart disease. Harding may not have been aware of how sick he was. Harding's physician, Dr. Charles Sawyer, misdiagnosed his case, despite symptoms of shortness of breath and blue lips.

President Warren Harding Visiting Vancouver En Route To Seattle
Photograph
1923
Courtesy of the Ohio Historical Society

In 1923, President Harding decided to take a trip to Alaska. Although the trip was clearly too much for Harding's declining stamina, Dr. Sawyer permitted the president to play golf, greet crowds, attend picnics and receptions, and walk in parades. An observer who saw Harding in Vancouver remarked that "The President is . . . an entirely exhausted man." Yet Dr. Sawyer allowed Harding to deliver an outdoor speech on a hot day in Seattle. The president, slurring his words, barely made it through the speech. That evening, Harding became ill. His remaining speeches were canceled and his train was ordered to run straight through to San Francisco.

President Harding's Death Announced in the Early Evening, Wilmington, Delaware, 3 August 1923
Courtesy of Andrea L. Kenyon

When questioned by reporters about the president's condition, Dr. Sawyer replied that he was suffering from food poisoning. Yet when other doctors examined Harding in San Francisco, they found his heart greatly enlarged. They called in Dr. Ray Lyman Wilber, an eminent cardiologist, who found that Harding was suffering from heart disease. At no time were the American people aware of the seriousness of the president's condition. News bulletins issued by Dr. Sawyer stated that Harding's illness was caused by indigestion. When Harding died on 2 August, Dr. Sawyer claimed that he died of a stroke. The other physicians did not agree, but they chose to keep their views to themselves rather than contradict Dr. Sawyer.

Dwight David Eisenhower
Portrait by James Anthony Wills
1967
Copyrighted by the White House Historical Society

Dwight Eisenhower, the 34th president of the United States, endured three major medical crises during his two terms in office. He suffered a heart attack in September 1955, underwent surgery for Crohn's disease in June 1956, and suffered a mild stroke in November 1957.

President Eisenhower Is Wheeled onto the Sun Deck at Fitzsimmons Army Hospital, Denver
Photograph
1956
Courtesy UPI/CORBIS-BETTMANN

Eisenhower suffered a heart attack on 25 September 1955 while vacationing in Denver, Colorado. The president instructed his press secretary, James Hagerty, to keep the public informed of his condition. "Tell them everything" he told Hagerty. While the public received detailed reports on the president's condition, they did not know that Eisenhower's personal physician, Dr. Howard Snyder, delayed a public announcement of the heart attack as long as he could. He instructed the president's private secretary to tell anyone who asked that Eisenhower was suffering from a "digestive upset."

President Eisenhower's Physicians and Press Secretaries Hold a Press Conference about Whether He Should Run for a Second Term
Photograph
14 February 1956
Courtesy of the Dwight D. Eisenhower Library

The medical team in charge of Eisenhower's case was comprised of four doctors, including the famous cardiologist, Dr. Paul Dudley White. While the team presented a unified front in public, members disagreed privately about Eisenhower's long-term prognosis and his running for a second term. Dr. White, the team leader, counseled the president not to run. Unable to convince Eisenhower, White reversed himself in public and declared at the 14 February press conference that the president "should be able to carry on an active life . . . for another five to ten years." If Dr. White had said what he really thought, Eisenhower may not have run or been re-elected.

Defibrillator Cardiac Pacer
Courtesy of the National Museum of Health and Medicine, Washington, D.C.

This is an early example of a cardiac pacer. The machine was kept at Eisenhower's home in Gettysburg, Pennsylvania, but apparently was never used by the president.

Ambulance Arrives at the White House following Announcement That President Eisenhower Would be Taken to Walter Reed Hospital
Photograph
8 June 1956
Courtesy of AP/Wide World Photograph

On 10 May 1956, six months before the presidential election, the president was diagnosed with Crohn's disease or ileitis, a disorder that may cause an obstruction in the intestines. Dr. Synder chose not to disclose this information to the public. It did not remain a secret for long. On 8 June the president suffered a severe attack of ileitis, which required surgery.

Brigadier General Leonard Heaton, President Eisenhower's Chief Surgeon, Explains the Ileitis Operation
Photograph
9 June 1956
Courtesy of UPI/CORBIS-BETTMANN

Three Weeks After His Ileitis Attack, President Eisenhower Leans Out of the Window of His Room at Walter Reed Hospital
Photograph
1956
Courtesy of UPI/CORBIS-BETTMANN

Eisenhower recovered from his ileitis surgery and won a second term as president. On 25 November 1957 he suffered a mild stroke while working in the Oval Office. He recovered from the stroke with only a slight speech impediment. The following year, Eisenhower gave his vice-president, Richard Nixon, a letter which gave the vice-president authority to assume the powers of the presidency in case he became incapacitated. Presidents Kennedy and Johnson made similar agreements.

A Gaunt President Eisenhower Leaves Walter Reed Hospital, 30 June 1956
Photograph
1956
Courtesy of the Dwight D. Eisenhower Library

John F. Kennedy
Photograph
date unknown
Courtesy of the John F. Kennedy Library

In the wake of President Eisenhower's medical problems, the health of the presidential candidates in the 1960 election be-

came an important issue. John F. Kennedy was acutely aware of this. While he projected youth, vigor, and fitness, he was hiding the fact that he had a life-threatening disease. If his health problems had been made public, Kennedy probably would not have been elected president.

A Sickly Looking John F. Kennedy Five Months After the Onset of Addison's Disease
Photograph
10 February 1948
Courtesy of the John F. Kennedy Library

Senator John F. Kennedy Accepting The Democratic Nomination for President at the Democratic National Convention, Los Angeles, California
Photograph
13 July 1960
Courtesy of UPI/BETTMANN NEWSPHOTOS

In 1947, Kennedy was diagnosed with Addison's disease, an incurable disorder of the adrenal glands. Despite Kennedy's health problems, his campaign insinuated that his rival for the nomination, Lyndon Johnson, was not healthy enough for the presidency because of his 1955 heart attack. In response, the Johnson campaign mentioned rumors of Kennedy's Addison's disease. Kennedy's people, including his personal physician Dr. Janet Travell, denied the charge vigorously: "John F. Kennedy has not, nor has he ever, had . . . Addison's disease."

President Kennedy Meets The Press
Photograph
19 July 1961
Courtesy of the John F. Kennedy Library

Kennedy was elected the 35th president of the United States in 1960. The secret of his Addison's disease was maintained through-

As a young Congressman, John F. Kennedy suffered from Addison's Disease. A new "wonder drug" brought his condition under control and improved his appearance.
Courtesy John F. Kennedy Library

out his short term in office. This photograph shows the swelling effects of cortisone, which Kennedy had been taking for Addison's disease since 1947.

President Kennedy Appears on Crutches After Re-Injuring His Back in Canada
Photograph
May 1961
Courtesy of the John F. Kennedy Library

While the American people knew that Kennedy had a bad back, they were not aware of the controversial treatment he was receiving for his back pain. Dr. Travell, who had been treating Kennedy for his back since 1955, was giving him injections of anesthetics, notably procaine. The president became addicted to the pain killers. At the advice of other physicians, Dr. Travell was replaced as the president's personal physician.

President Lyndon B. Johnson
Photograph
date unknown
Courtesy of Arnold Newman, LBJ Library Collection

Over the Labor Day weekend of 1965, President Lyndon Baines Johnson suffered a gallbladder attack. Surgery was recommended for the 36th president of the United States. Always secretive about his health, Johnson did not want to inform the public about the operation.

President Johnson Is Prepared to Undergo Gall Bladder Surgery at the Bethesda Naval Hospital
Photograph
1965
Courtesy of Yoichi R. Okamoto, LBJ Library Collection

After consulting with former President Eisenhower, Johnson decided on a policy of full disclosure regarding his condition and the surgery. The two-hour operation involved the removal of the president's gallbladder and a gallstone, as well as a stone from his ureter.

Press Secretary Bill Moyers' News Conference on the President's Gall Bladder Surgery
Photograph
1965
Courtesy of Yoichi R. Okamoto, LBJ Library Collection

President Johnson wanted the public to know that he was recovering and in control. The day after his operation, he signed a major anti-poverty bill in his hospital room.

Convalescing From His Gall Bladder Operation, President Johnson Meets with Vice-President Hubert H. Humphrey
Photograph
1965
Courtesy of Yoichi R. Okamoto, LBJ Library Collection

Before his surgery, Johnson informed Vice-President Hubert Humphrey in great detail about what should be done in case he should be incapable of carrying out his presidential duties after the operation.

President Johnson Shows His Surgical Bandage and Scar
Photograph
1965
Courtesy of UPI/CORBIS-BETTMANN

The president shows the world his scar to illustrate just where it was that the surgeons "messed around" in his abdomen. A friend of the president said at the time "I don't know anyone else who would open up and show his gall bladder scar."

President Johnson Makes Traditional "O.K." Sign to Newsmen in His Room at Bethesda Naval Hospital
Photograph
1966
Courtesy of UPI/CORBIS-BETTMANN

President Johnson was in the hospital again in November 1966 to have a nonmalignant growth removed from his throat and for the repair of a small hernia. Again, the administration was open about the president's condition.

Recent Presidents: The Picture of Health

As we have seen in this exhibit, health has played a significant role in the lives of many of our presidents. Yet it was not until John F. Kennedy's campaign and the subsequent impact of television that health became such an important issue for presidents and presidential candidates. In today's media-conscious world, presidential candidates and presidents use symbols and positive images to communicate their messages, pass legislation, and get elected to office. Good health—or the appearance of it—adds to a positive image.

Today, managing a president's health is not just a medical challenge, but a delicate public relations issue. Recent presidents and presidential candidates have endeavored to show the American people that they are "the picture of health."

President Reagan Gives an "O.K." Sign as Mrs. Reagan Waves From a Bethesda Naval Hospital Window
Photograph
July 1985
Courtesy of UPI/BETTMANN

At age 69, Ronald Reagan was the oldest man to be elected president. Due to his age, the administration felt that it was important to show the president as robust and healthy. He was shown horseback riding, chopping wood, and telling jokes while recovering from the assassination attempt. Here the president is shown in good spirits after colon surgery to remove malignant polyps.

President Carter Jogging
Photograph
1979
Courtesy of UPI/BETTMANN

President Jimmy Carter played softball and tennis, and he also jogged. Jogging near Camp David in September 1979, he collapsed moments after this photograph was taken. The American public had noticed how much the presidency had aged Carter, and his collapse reinforced the perception that the office was too much for him.

President George Bush
Photograph
date unknown
Courtesy of the National Archives

President George Bush was an avid jogger during his term in the White House. On 4 May 1991, while jogging at Camp David, the president developed an irregular heartbeat, which was caused by Graves disease or hyperthyroidism. This and later episodes concerned the American public.

President Clinton Jogging
Photograph
March 1994
Courtesy of AP/Wide World Photograph

Like his immediate predecessors, President Bill Clinton is projected as a healthy president. He is often shown jogging and playing golf.

Grover Cleveland (1885–1889, 1893–1897): The Secret Operation

On 1 July 1893, an operation was performed on President Grover Cleveland to remove a cancerous lesion from his left upper jaw. The operation took place on a private yacht as it steamed up Long Island Sound to the president's summer home in Massachusetts. Performing the surgery was Dr. Joseph D. Bryant of New York,

assisted by Dr. W. W. Keen of Philadelphia, three other doctors, and a dentist.

The surgeons performed the entire operation inside the mouth without making any external incision. Two weeks later, a second operation was done, again on the yacht, to remove additional suspicious tissue. A vulcanized rubber plate was made for the president, which restored his speaking voice so well that when he reappeared in public, no one could detect that an operation had taken place.

Despite all the care taken to prevent publicity, the story broke on 29 August in the *Philadelphia Press*. It was firmly denied by the White House and Cleveland's friends and family. The official word was that the president had had a bad tooth extracted.

The reason for the secrecy was that the country was in the middle of a financial crisis caused by the inflationary Sherman Silver Purchase Act of 1890. Cleveland had been elected to a second term on a platform that called for repeal of the Act and his leadership was essential to that process, which was to begin at a special session of Congress on 7 August 1893. His vice-president, Adlai Stevenson, was a "silver man" and opposed to the repeal. Feeling that any sign of ill health might be interpreted as weakness and throw support to the pro-silver side, Cleveland decided to keep the operation secret.

President Cleveland's Second Inauguration
Photograph
4 March 1893
Courtesy of the Library of Congress

President Cleveland was the standard-bearer of a Democratic Party that was split into two factions—the conservative pro-business gold standard faction which he led, and the free-silver faction led by William Jennings Bryan. Cleveland defeated President Benjamin Harrison's re-election bid in 1892 by campaigning on a sound-money platform, but was able to carry his party only by choosing free-silver advocate Adlai Stevenson as his running mate.

President Grover Cleveland
Plaster statue by unknown artist
date unknown
Courtesy of the New Jersey Department of Environment Protection, Division of Parks and Forestry, Walt Whitman House, Camden, New Jersey

This is one of a pair that stood beside Walt Whitman's fireplace at his home in Camden, New Jersey.

The Yacht *Oneida*
Photograph
date unknown
Courtesy of UPI/CORBIS-BETTMANN

Given the political climate, Cleveland decided that the operation should be kept secret. Plans were made to assemble a surgical team selected by Dr. Bryant on the private yacht *Oneida*, owned by Cleveland's friend, Commodore Elias C. Benedict.

The Operation on President Cleveland, 1 July 1893, in the Stateroom of the *Oneida*
Painting by Chevalier Fortunio Matania
date unknown
Reproduced with the permission of SmithKline Beecham

President Cleveland is in the center, with Dr. Edward Gamaliel Janeway, medical consultant, in the left foreground, and in the rear, left to right, Drs. Ferdinand Hasbrouck, Robert M. O'Reilly, Bryant, and Keen.

Cheek Retractor
By Luer, Paris

Dr. Keen wrote that, "The entire operation was done within the mouth, without

any external incision, by means of a cheek retractor, the most useful instrument I have ever seen for such an operation, which I had brought back from Paris in 1866."

Laryngeal Mirror Used in President Cleveland's Operation

Plaster Cast of President Cleveland's Jaw Made by Dr. Kasson C. Gibson After the Operation on 1 July 1893
Courtesy of the New York Academy of Medicine

Plaster Cast of President Cleveland's Jaw in 1897, Showing the Extent to Which Healing Had Taken Place
Courtesy of the New York Academy of Medicine

Dr. Kasson C. Gibson, a New York prosthodontist, was called up to the President's summer home to make a vulcanized rubber prosthesis to fill in the large defect in the President's palate and restore his speech to normal.

Specimen Removed from the Left Upper Jaw of President Grover Cleveland on 1 July 1893

From the time of the operation, questions lingered as to the exact nature of the lesion and its malignancy. In 1975, a reexamination of the tissue determined that it was a verrucous carcinoma of the hard palate and gingiva, which fit the clinical features of the case as described by Drs. O'Reilly, Keen, and others. Unlike the highly metastatic oral cancer squamous carcinoma, it is usually cured by surgical excision.

Dr. William Williams Keen
Portrait by James L. Wood
1901

Dr. Keen was professor of surgery at Jefferson Medical College from 1889 to 1907, and was known as a bold and innovative surgeon and was recognized as a leader in his field.

W. W. Keen, The Surgical Operations on President Cleveland in 1893 (Philadelphia, 1917)

This book is a reprint of Keen's 1917 *Saturday Evening Post* article. In his foreword, Keen notes that he felt it was his duty to bring the facts before the public before it was too late. He also wished to vindicate the reputation of E. J. Edwards of the *Philadelphia Press*, who had accurately reported the operation in August 1893, but whose truthfulness was violently attacked by those trying to maintain the coverup. Keen concluded that Cleveland's decision to keep the operation a secret had been a wise one.

Grover Cleveland
Portrait by Jonathan Eastman Johnson
1891
Copyrighted by the White House Historical Association. Photograph by the National Geographic Society

After his operation, Cleveland returned to Washington for the special session of Congress he had called on 7 August. With his urging, the House passed the repeal of the Sherman Act on 28 August. The fight in the Senate continued at greater length, and the repeal was not finally passed until 30 October.

Letter from President Cleveland to Dr. Kasson C. Gibson, 14 October 1893
Manuscript
Courtesy of the New Jersey Department of Environmental Protection, New Jersey State Park Service, Grover Cleveland Birthplace, Caldwell, New Jersey

Cleveland writes: "My dear Doctor, I hasten to announce that you have scored another dental victory and a greater one than has before attended your manipulation of

my corpus. The new plate came last night. . . . I have worn it all day with the utmost ease and comfort . . . my wife says that my voice and articulation are now much better than they have been for a number of days . . . If I could only regain my strength and hearing I should feel quite like myself."

Pipes, Cigar Case, and Cigar Cutter Belonging to President Grover Cleveland
Courtesy of the New Jersey Department of Environmental Protection, New Jersey State Park Service, Grover Cleveland Birthplace, Caldwell, New Jersey

Verrucous carcinoma is typically associated with the use of tobacco and alcohol. Cleveland occasionally drank spirits and was very fond of beer; he also enjoyed smoking both cigars and pipes.

Woodrow Wilson (1913–1921): The Disabled Presidency

Woodrow Wilson, the 28th president of the United States, served two terms in the White House. Wilson appeared to be in good health when he was elected president in 1912. He was re-elected four years later, and the beginning of his second term was dominated by World War I. At the conclusion of the war in 1918, Wilson went to Paris to personally negotiate a peace treaty with our Allied partners. Wilson advocated his own peace plan, which included the creation of the League of Nations. The president neither consulted the Senate when preparing the plan nor when negotiating it with the Allies. This was a political blunder on Wilson's part. When he presented the treaty to the Senate, Wilson expected its passage with no changes. Republican senators vowed to defeat the treaty unless changes were made.

Physically exhausted from the intense treaty negotiations, Wilson in August 1919 embarked on a grueling speaking tour to seek the support of the American people. During the trip, Wilson complained of headaches and sleeplessness. He collapsed in Pueblo, Colorado. The trip was canceled and Wilson returned to the White House, where he suffered a stroke. From that time on the president was incapable of carrying out his duties. Wilson's inner circle consisting of the First Lady, his personal physician, private secretary, and the Secretary of State, kept the president's condition a secret. No one was allowed to see him. The cabinet and press were told that Wilson had suffered a nervous breakdown. Vice-President Thomas Marshall was never informed. The American people never knew that their president was an invalid. Wilson completed his second term in office in 1921. His health improved only slightly. He died in retirement on 3 February 1924.

Woodrow Wilson
Photograph by Moffety, Chicago, Illinois
1912
Courtesy of the Woodrow Wilson House, Washington, D.C.

This photograph shows Wilson in 1912, the first year of his presidency. Some historians have claimed that Wilson suffered three strokes before he became president and thus should never have been elected. These contentions cannot be proven, however.

President Woodrow Wilson's Second Inaugural Address
Photograph
5 March 1917
Courtesy of the National Archives

President Woodrow Wilson Arriving in Paris
Photograph
14 December 1918
Courtesy of the Library of Congress

World War I and the negotiations which ended the hostilities dominated President Wilson's second term until his stroke in

1919. When Wilson arrived in Paris for the peace negotiations, he received a hero's welcome from the French people.

Itinerary of President Wilson's Speaking Tour on Behalf of the Paris Peace Treaty and the League of Nations
1919
Courtesy of the Woodrow Wilson House, Washington, D.C.

The itinerary shows the extent of Wilson's speaking tour. The itinerary is opened to the part of the tour that included a stop in Pueblo, Colorado, where Wilson collapsed.

President Wilson Meets With His Cabinet After His Stroke
Photograph
1920
Courtesy of the Woodrow Wilson House, Washington, D.C.

Wilson did not attend a cabinet meeting until almost six months after his stroke. When he finally attended one in April 1920, his feeble condition shocked cabinet members. Most of Wilson's cabinet still did not know the true state of his health.

Cane Owned by Woodrow Wilson
Courtesy of the Woodrow Wilson House, Washington, D.C.

After his stroke, President Wilson used a cane for support while walking.

Former President Wilson on the Front Porch of His Washington Residence
Photograph
date unknown
Courtesy of the Woodrow Wilson House, Washington, D.C.

Woodrow Wilson After His Stroke
Photograph
date unknown
Courtesy of the Woodrow Wilson House, Washington, D.C.

Former President Wilson Assisted by Attendant While Leaving His Washington Residence
Photograph
date unknown
Courtesy of the Woodrow Wilson House, Washington, D.C.

Former President Wilson Takes an Automobile Ride With Former First Lady Edith Wilson
Photograph
date unknown
Courtesy of the Woodrow Wilson House, Washington, D.C.

After leaving the presidency, Wilson moved to a house in Washington, D.C. Here he lived the life of an invalid. He rarely appeared in public, except for occasional automobile rides with his wife.

Diary of Former President Wilson's Night Nurse
Manuscript
1 January–31 December 1924
Courtesy of the Woodrow Wilson House, Washington, D.C.

This diary, opened to entries made on 21–22 February 1924, indicates that Wilson required full-time medical assistance after he left the White House.

Pince-Nez Owned by Woodrow Wilson
Made by J. H. Edmonds, Washington, D.C.
Courtesy of the Woodrow Wilson House, Washington, D.C.

Rear Admiral Cary T. Grayson With President Wilson Before His Stroke
Photograph
date unknown
Reproduced from Gary T. Grayson, *Woodrow Wilson: An Intimate Memoir* (1960)

Dr. Grayson was President Wilson's personal physician. Out of loyalty to the president, Dr. Grayson refused to declare

Wilson disabled after his stroke. He never admitted publicly that Wilson had suffered a stroke. Dr. Grayson was, along with Mrs. Wilson, one of the inner circle that prevented people from seeing the sick president.

Violet Ray Machine
Made by Thompson Olaster X-Ray Company, Leesburg, Virginia
Courtesy of the Woodrow Wilson House, Washington, D.C.

This device was apparently used to help President Wilson to recover from the debilitating effects of the stroke.

Automobile Blanket
1915
Courtesy of Woodrow Wilson House, Washington, D.C.

Blanket used to keep the president and the First Lady warm when they took automobile rides in the cold weather.

Robe
Made by Stinemetz, Washington, D.C.
1920
Courtesy of the Woodrow Wilson House, Washington, D.C.

Robe worn by former President Wilson during his retirement.

Franklin Delano Roosevelt (1933–1945): The Dying President

Franklin D. Roosevelt, the 32nd president of the United States, was elected to an unprecedented third term in 1940. It was during the end of this term that FDR's health began to decline. The strain of leading the country through World War II had begun to take its toll. Exhausted from a summit in Teheran with Winston Churchill and Josef Stalin at the end of 1943, FDR's health began to deteriorate rapidly after his return. Months passed and the president did not bounce back. He lost weight, his face thinned, and he suffered shortness of breath. At first, FDR's personal physician, Vice Admiral Ross T. McIntire diagnosed the president's problem as the "flu" and bronchitis.

Not satisfied with the diagnosis, FDR's family wanted a second opinion. Dr. McIntire arranged to have the president examined at Bethesda Naval Hospital in March 1944 by Dr. Howard G. Bruenn. Dr. Bruenn, a cardiologist, found that FDR was suffering from hypertension, heart disease, left ventricular cardiac failure, and bronchitis. He recommended that FDR be given digitalis, put on a diet, and have bed rest. No one told the president of his serious condition, and he never asked.

FDR decided to run for a fourth term in 1944. No one made a serious attempt to persuade the president not to run or inform him of his health problems. While those who saw the president were shocked at his appearance, they were assured by FDR's spokesmen that there was nothing to be concerned about. Less than a month before the election, Dr. McIntire claimed that FDR's health was "perfectly OK." FDR was re-elected in 1944, and soon thereafter attended a summit in Yalta with Churchill and Stalin. It was a strenuous trip for the ailing FDR, but he appeared to be alert.

President Franklin D. Roosevelt
Photograph
date unknown
Courtesy of Thomas A. Horrocks

FDR was one of this country's most popular presidents. He was elected to an unprecedented four terms.

Roosevelt at Hyde Park in a Wheelchair
Photograph
1941
Courtesy of the Franklin D. Roosevelt Library

One of only two known photographs of FDR in a wheelchair. FDR contracted polio in 1921. Few Americans were ever aware of FDR's disability. This was due in large part to the cooperation of members of the press, who almost always photographed him from the waist up. FDR insisted on this policy when he re-entered politics after his bout with polio, and it was continued during his presidency.

Campaign Poster for Franklin D. Roosevelt and Harry Truman
Photographic reproduction of poster
1944
Courtesy of the Franklin D. Roosevelt Library

President Roosevelt Lunches With Harry Truman on the White House Lawn
Photograph
18 August 1944
Courtesy of AP/World Wide Photograph

When he ran for a fourth term in 1944, FDR chose Senator Harry Truman of Missouri as his vice-president. Their lunch gave the two men a chance to meet and discuss the presidential campaign. Truman was deeply concerned about FDR's unhealthy appearance.

"I Want You FDR—Stay And Finish The Job." Campaign Poster
Photographic reproduction of poster
1944
Courtesy of the Franklin D. Roosevelt Library

American voters were not aware of the seriousness of FDR's medical condition when he ran for a fourth term.

Blood Pressure Readings, Washington, D.C.
Manuscript
9 April–1 May 1944
Courtesy of the Franklin D. Roosevelt Library

FDR's blood pressure during 1944 reached dangerously high levels. In the wake of the president's examination at Bethesda Naval Hospital in March of that year, FDR's blood pressure was monitored closely. This chart shows that his blood pressure remained very high for the month of April 1944.

Treatment of Hypertension
Manuscript
1944
Courtesy of the Franklin D. Roosevelt Library

One of Dr. Bruenn's 1944 recommendations for FDR's health was bed rest. Here we see that FDR was supposed to take brief naps during the day and get 10 hours of sleep each night. When Dr. Bruenn recommended this regimen, FDR's physician, Dr. McIntire, replied "You can't do that. He's the president of the United States."

President Roosevelt Campaigns in New York City
Photograph
21 October 1944
Courtesy of AP/World Wide Photograph

To dispel rumors concerning the president's health, FDR's advisors sent him out on the campaign trail.

Leg Braces Worn by Franklin D. Roosevelt
Courtesy of the Franklin D. Roosevelt Library

As the result of polio, FDR could neither stand nor walk without leg braces. When he did walk, FDR had to be supported by another person, usually one of his sons. When he reported to Congress on the Yalta conference on 1 March 1945, FDR made what was perhaps his only public reference to his braces. Apologizing for sitting down during his address, FDR stated that he was carrying around 10 pounds of steel.

President Roosevelt's Re-Election to a Fourth Term Announced by The Philadelphia Inquirer, 8 November 1944
Courtesy of Andrea L. Kenyon

President Roosevelt's Fourth Inaugural Address, Presented at the White House
Photograph
20 January 1945
Courtesy of UPI/CORBIS-BETTMANN

Americans did not realize that they had re-elected a dying president.

Vice Admiral Ross T. McIntire
date unknown
Photograph

Dr. McIntire was selected as Roosevelt's personal physician at the recommendation of Dr. Cary D. Grayson, who had been President Woodrow Wilson's personal doctor. An eye, ear, nose, and throat specialist, Dr. McIntire appeared to have been chosen because FDR suffered from chronic sinus trouble. Shortly after FDR's death, Dr. McIntire wrote (contrary to fact) that FDR's blood pressure and heart signs had been normal. Dr. McIntire has been accused by historians of destroying FDR's medical records to hide his misdiagnosis and mismanagement of the president's case.

President Roosevelt at the Yalta Conference
Photograph
9 February 1945
Courtesy of the Franklin D. Roosevelt Library

Two months before his death, FDR traveled to Yalta to meet with Winston Churchill and Josef Stalin. His physical decline is clearly apparent from the photographs taken at the conference.

President Roosevelt Addresses Congress on His Return from the Yalta Conference
Photograph
1 March 1945
Courtesy of the Franklin D. Roosevelt Library

A tired and worn out president informs Congress about the agreements he made with Churchill and Stalin at Yalta. The question of whether FDR's health compromised his bargaining power with Stalin has been debated.

President Roosevelt Working at Warm Springs, Georgia
Photograph by Margaret L. Suckley
1945
Courtesy of the Franklin D. Roosevelt Library

To escape the pressures of Washington, FDR often vacationed at the "Little White House," a cottage in Warm Springs, Georgia. FDR went to the cottage on 29 March

Since he wanted to be perceived as a strong leader, President Roosevelt rarely allowed himself to be photographed in his wheelchair.
Courtesy Franklin D. Roosevelt Library

1945 for a brief vacation. This picture was taken shortly before his death.

President Roosevelt at Warm Springs, Georgia, the Day Before His Death
Photograph
11 April 1945
Courtesy of the Franklin D. Roosevelt Library

This was the last photograph taken of FDR. The next day the president, while working at his desk, complained of a "terrific pain" in the back of his head. The pain was a stroke. FDR died at 3:35 P.M.

President Roosevelt's Death Announced in The Philadelphia Inquirer, 13 April 1945
Courtesy of Andrea L. Kenyon

Is There a Doctor in the (White) House?: The Medical Care of Our Presidents

Tracing the evolution of the White House physician illuminates the changing practice of American medicine and the incredible pressures that confront physicians when their patient is the president.

There are no specific criteria for the selection of the White House physician to ensure that the most qualified and appropriate person is selected for the position. Presidents have chosen their own physicians. Their choice has often been one of convenience, or as the result of friendship, geographical location, or expediency. Rarely has the choice been based solely on professional medical skills and experience.

In reaction to past coverups and criticisms of presidential medical treatment, questions have arisen regarding the current system of providing medical care to the president. Does the present system ensure that the president obtains state-of-the-art medical treatment? What can be done to ensure the best medical care?

Many point to the White House physician as the logical person to determine the president's state of health and ability to carry out the responsibilities of the office. But how can we be sure that the White House physician is the best person to provide this vital information? Can the public be assured of the White House physician's objectivity? Should the White House physician be loyal to the president or to the nation? Can the White House physician be both?

Physicians Walking Toward the White House
Drawing by Elizabeth Wolf
date unknown
Courtesy of Elizabeth Wolf

18th-Century Medicine

Physicians associated health with balances among the body's four fluids or "humors"—blood, phlegm, yellow bile, and black bile—and the strength and elasticity of the blood vessels and nerves. The body was healthy when these fluids could freely circulate or be expelled from the body. There was no concept of specific diseases with specific causes and treatments. Doctors focused on their patients' symptoms and provided appropriate therapies. Preference was given to drugs and treatments that had observable results—stimulants such as emetics, diuretics, and electricity, and sedatives such as narcotics, cathartics, and bleeding.

Medicine Chest Once Owned by Dr. Benjamin Rush

Enema Syringe
Tooth Key
Bleeding Cup
Lancet

19th-Century Medicine

Medicine underwent enormous changes in the 19th century. Diagnostic instruments progressed from the invention of the stethoscope in 1816 to the discovery of X-rays in 1895. Concepts of disease were

transformed from the humoral theory to precise identification of specific disease-causing microorganisms. By the time of the Civil War, chloroform and ether had been used as anesthetics for almost 20 years. Lister's antiseptic surgical techniques followed the germ theory of Pasteur and the bacteriology of Koch in the latter half of the century.

Chloroform Mask
Monaural Stethoscope
Clinical Thermometer, 1860s–1880s
Surgical Instrument Case, ca. 1865

20th-Century Medicine

This century has seen major developments in the diagnosis, treatment, and prevention of disease. The body-imaging of X-rays has been complemented by CAT-scans and MRIs, providing more information on physical changes in the body, while biochemistry and molecular biology have provided new insights into how the body functions. Antisepsis and asepsis, fully established by the beginning of the century, have expanded the range of successful surgical procedures, and the discovery of antibiotics such as penicillin in 1945 has helped diminish the threat of infection. New vaccines have made it possible to prevent many former public health hazards such as polio and rabies, and have drastically reduced mortality from childhood diseases.

Hypodermic Kit
Stainless Steel Scalpel Set
Electric Sterilizer
Penicillin
Polio/DPT Vaccine
Rabies Vaccine

Benjamin Rush
Portrait by Adele von Helmbold after Thomas Sully
date unknown

Dr. Rush, a prominent Philadelphia physician and signer of the Declaration of Independence, prescribed treatment for President Thomas Jefferson's recurrent diarrhea.

Robert King Stone, M.D.
Photograph
date unknown
Reproduced from Joshua L. Chamberlain (ed.), *Universities and Their Sons . . .* (1902)

Dr. Stone treated President Abraham Lincoln and his family while they were living in the White House.

James Craik, M.D.
Portrait by unknown artist
date unknown
Reproduced from James Evelyn Pilcher, *The Surgeon Generals of the Army of the United States of America* (1905)

During the 18th and most of the 19th centuries there was no physician on duty at the White House. Presidents used family physicians, or solicited treatment from prominent civilian or military physicians whose fees they paid out of their own pocket. Dr. Craik was a personal friend of President George Washington and his family.

Jebediah Hyde Baxter
Photograph
date unknown
Reproduced from James Evelyn Pilcher, *The Surgeon Generals of the Army of the United States of America* (1905)

Dr. Baxter served both Presidents James A. Garfield and Benjamin Harrison. It appears that professional competition and animosity kept his name from being included among the attending surgeons after Garfield was shot. Harrison appointed him Surgeon General of the United States Army in 1890. Often the president's physician was rewarded by being appointed Surgeon General of the Army or Navy.

Today presidents continue to rely on military doctors for their treatment.

Basil Norris, M.D.
Photograph
date unknown
Reproduced from supplement to *Notes and Abstracts*, Vol. 11 (1927)

Presidents increasingly began to rely on government medical services in the mid-19th century. This was a custom rather than an officially sanctioned and financed activity that caused some controversy. Dr. Norris was a surgeon in the United States Army who attended Presidents Andrew Johnson and Ulysses S. Grant during their terms of office.

Newton L. Bates, M.D.
Photograph
date unknown

The position of White House physician was created in the late 19th century. Dr. Bates was the first government-paid presidential physician. He died shortly after his appointment by President William McKinley.

Presley M. Rixey, M.D.
Photograph
date unknown

Dr. Rixey was White House physician at the time of President McKinley's death. He continued to serve in this capacity during President Theodore Roosevelt's two terms.

". . . The President sent for me and directed that in the future I was to be White House Physician and that I should make two calls, 10 A.M. and 10 P.M. at the Executive Mansion and hold myself in readiness to accompany him and Mrs. McKinley whenever they left Washington."

Howard Whitmore Snyder, M.D.
Portrait by President Dwight D. Eisenhower
date unknown
Courtesy of Howard M. Synder, M.D.

Dr. Synder came out of retirement to serve as President Dwight D. Eisenhower's physician. He previously served as his physician during World War II. He encouraged the president to play golf, exercise, and to paint for relaxation.

William Lukash, M.D.
Photograph
1976
Courtesy of the Gerald R. Ford Library

Dr. Lukash gives President Gerald Ford his swine flu shot. Dr. Lukash, a military gastroenterologist, headed the White House Medical Unit during the terms of Presidents Lyndon Johnson, Richard Nixon, Gerald Ford and Jimmy Carter.

Ross T. McIntire, M.D.
Photograph
date unknown

There are no written guidelines to follow should the White House physician suspect that the president is incapable of fulfilling the duties of the office. Dr. McIntire's care of President Franklin Roosevelt has been called into question. In 1944, when reporting on the president's health, Dr. McIntire stated "The President's health is perfectly ok. There are absolutely no organic difficulties at all." FDR died of a stroke months later.

Janet G. Travell, M.D.
Photograph
date unknown
Courtesy of UPI/BETTMANN

White House physicians, when reporting on the president's health, have sometimes found themselves torn between loyalty to the president and serving the nation's interest. Dr. Travell was the first woman to hold the post of White House physician. She issued to the press evasive medical statements in order to cover up the fact

President Roosevelt was a dying man when he sought a fourth term in 1944.
Courtesy Franklin D. Roosevelt Library

that President John F. Kennedy suffered from Addison's disease.

Is This Job For You?

Global executive seeks M.D. to serve as personal physician. Responsible for round-the-clock medical care. Supervises medical unit staff of approximately 16 military personnel. Provides medical care to executive's family, second-in-command, cabinet members and executive branch employees. Private office on ground floor of residence. Additional treatment facilities in nearby Executive Office Building.

Ideal candidate will be able to successfully interact with government bureaucracy, reporters, and politicians. Confidentiality regarding employer's business and personal activities a must. Extensive international travel required. Salary commensurate with experience and/or military rank. Send resume and references to President of the United States, The White House, Washington, D.C.

"Somebody who understands his role, doesn't think he has to be in the foreground, and doesn't mind sometimes riding in the back of the airplane." Retired Brigadier General John E. Hutton, Jr., M.D., physician to President Ronald Reagan.

Presidential Disability and the 25th Amendment

When the Founding Fathers created the office of the presidency as part of the Constitution, they chose not to get involved in details concerning the concept of presidential disability. When the chief executive was unable to "discharge the Powers and Duties" of the presidency, those duties were to fall to the vice-president "until the Disability be removed, or a president shall be elected." The Founders did not explain what they meant by "inability" or "disability." Nor was any procedure created to determine when a president was disabled.

As we have seen in this exhibit, several presidents were disabled during at least part of their administrations. President Woodrow Wilson, for example, was clearly incapable of carrying out the duties of the office during his last year in the White House. Yet it was not until 1967, with the adoption of the 25th Amendment to the Constitution, that a procedure was established to address the issue of presidential disability.

Because the 25th Amendment has never been invoked, we do not know how effectively it will work. The assassination attempt of President Reagan in 1981 was the first opportunity to test the disability provisions of the amendment. The Reagan administration, however, decided not to invoke the amendment. Yet when President Reagan underwent cancer surgery in 1985, he did transfer power to Vice-President George Bush. Bush was Acting President for eight hours.

Because the 25th Amendment does not define "disability," important questions remain: What does the term mean? Who decides?

From the Fellowship

Memoir: Jonathan E. Rhoads, M.D., 1907–2002

Clyde F. Barker, M.D.

One of the 20th-century's great surgeons, Jonathan E. Rhoads, died at age 94 on January 3, 2002. His active career spanned the last three-quarters of the century and was responsible for one of the most important medical advances of that period, while contributing to several others. His impact was felt not only on surgery and medicine but also on other aspects of science, and a variety of civic and academic affairs. Although he was an international figure he was particularly attentive to the institutions of his native city, Philadelphia, where his forbearers had lived since the 1600s. He served in leadership positions in the University of Pennsylvania, Haverford and Bryn Mawr Colleges, the Board of Education, the American Philosophical Society and the College of Physicians. In the bicentennial year of 1976, the city reciprocated by awarding Dr. Rhoads its highest honor, the Philadelphia Award.

Dr. Rhoads placed the College of Physicians high on his list of interests. A Fellow since 1945, he served as President (1958–60), Chairman of the Library Committee (1952–54), and Censor (1965–75), and was a member of the Committee on Planning and Development and the Steering Committee of the Francis C. Wood Institute for the History of Medicine (1982–1990). In celebration of its 200th anniversary in 1987, the College made four Distinguished Service Awards to honor its most deserving past and present members. One award went to John Gibbon (posthumously) for the discovery of the heart-lung machine, one to Britton Chance and Mildred Cohn for the MRI, one to Robert Gallo for AIDS research, and one to Jonathan Rhoads for development of intravenous hyperalimentation. At the time of his death Dr. Rhoads remained active on the Editorial Board of *Transactions & Studies*. Throughout his life he

continued to attend meetings of the College regularly, including a lecture of the Wood Institute only two weeks before his death.

Jonathan Evans Rhoads was born on May 9, 1907. His father, Edward, was a physician, who served his internship under D. Hayes Agnew and William Osler at the Hospital of the University of Pennsylvania in 1885, just eleven years after the nation's first university hospital opened. At Haverford College, Jonathan majored in chemistry and mathematics, wrote for the school newspaper, and was an outstanding athlete, starring in pole-vaulting. During the only extended period of his life in which he lived away from Philadelphia, he attended medical school at Johns Hopkins. There he met his classmate and future wife, Terry Folin, whose father Otto was the Professor of Biochemistry at Harvard. After graduation in 1932, Jonathan accepted an internship at the Hospital of the University of Pennsylvania and Terry one at Yale. He credited her with the predominant role in raising their six children, for which she gave up a promising career in pediatrics. Their marriage of 51 years ended in 1987 with Terry's sudden death from heart disease.

During Dr. Rhoads's training in surgery at the Hospital of the University of Pennsylvania (1934–39), Eldridge Eliason was the department chairman, but his real mentor was I.S. Ravdin. The confidence Ravdin placed in him was emphasized by his selection of Rhoads as the operating surgeon when Ravdin required an operation for acute cholecystitis only nine months after Rhoads was appointed to the faculty.

Rhoads's early faculty years at Penn, where he spent his entire career, were highly productive. He later wrote:

> We began using Wangensteen Suction in 1933 or 34 and with William Osler Abbott participated in defining the use of the Miller-Abbott tube. We operated on the first cases of Crohn's disease in 1933 and I believe the first islet cell adenoma of the pancreas about 1936. We attempted to transplant slices of it into the rectus muscle of a diabetic and to get the cells to grow in tissue culture. We got sulfanilamide in 1936, sulfadiazine by 1938, and Vitamin K in 1938. I set up the Quick test for prothrombin in 1938 and personally ran all the prothrombins. About 1935, I did the first four peritoneal dialyses for uremia that were done in the Philadelphia area [probably the first anywhere]. We studied the effect of hypoproteinemia on wound healing and later its effect on hemorrhagic shock. I studied

> blood coagulation . . . [and demonstrated] that the prothrombin fell rapidly in the hepatectomized dog.

To review Rhoads's bibliography from its first entry in 1935 to the most recent of his nearly 400 papers, which was published in 2001, is to chart the progress in the entire field of surgery over the last seven decades. He wrote on virtually every subject and many of his papers were seminal. His most lasting and important contributions were in the field of nutrition. Close behind was his broad interest in neoplasia. He wrote important papers on pancreatic, gastric, colon, and breast cancer and on a tumor marker for liver cancer. He was a pioneer in the study of coagulation and the use of vitamin K and coumadin. During his early career he was a recognized expert on shock and on burns, writing prolifically on both. He was one of the first to use the sulfas for burns and peritonitis. Streptomycin became available just at the time he was diagnosed with advanced tuberculosis in 1946. His own experience with eighth nerve damage helped to define the toxicity of this drug, which also fortunately cured his disease. Other subjects of his reports were thyroid and parathyroid disease, parotid tumors, portal hypertension, intestinal obstruction, hernia, biliary surgery, wound healing, inflammatory bowel disease, and pediatric surgery (with his trainee, a young C. Everett Koop).

On some topics he wrote only a single paper but this was often an important one. His solitary work on peritoneal dialysis influenced W.J. Kolff, who is generally credited with the introduction of dialysis. In 1949, his case report on a patient with gastric hyperchlorydria associated with multiple jejunal perforations, eventually treated successfully by total gastrectomy, was of considerable interest to Dr. Robert Zollinger in his later description of the well-known "Zollinger-Ellison" syndrome.

In other instances Rhoads carried out innovative procedures, which were never reported. He wrote:

> In 1945 we were called to see a patient with toxemia of pregnancy, who had developed both liver and renal failure, with a mounting blood urea. I purchased some Visking tubing, a product made primarily as a substitute sausage casing but known to have excellent properties as a dialyzing membrane . . . We did an arterial puncture and allowed the blood to course through the tubing, which was rolled around a wire

> test tube rack, [and] immersed in a basin of [dialysis] solution. The blood was then collected and returned to the patient by way of gravity into an arm vein . . . This *in vivo* dialysis was highly successful in extracting urea from the patient . . . and the blood urea nitrogen was reduced. Unfortunately, the patient had a hemorrhage that night (from which she did not die) but we had somewhat the feeling that logical as the approach may have been, it might have hastened her exit. Whether it did or not, it certainly did not save her and again we turned away from a procedure, which W.J. Kolff developed in Holland under far greater difficulties . . . When Kolff visited the United States shortly after the war, he came to see me at the University of Pennsylvania. He mentioned our report on peritoneal dialysis and asked why we had not continued with it. The answer was simply that the patients, although they had been selected as possible acute renal shut down, proved to have chronic renal disease and did not improve. I believe that Kolff's experience was that he did eleven patients with only one survivor, but he did observe improvement of a temporary nature in some of the others.

In 1959, Dr. Rhoads succeeded I.S. Ravdin as John Rhea Barton Professor and Chairman of the Department of Surgery at the University of Pennsylvania. It was as chairman that he most clearly proved to be a "triple threat" academic surgeon (clinician, scientist, and teacher). Despite his preeminence in Philadelphia as the chief of a busy clinical service, future generations will most remember Rhoads for his work in the research laboratory, where he directed the project that established the feasibility of total parenteral nutrition, a procedure which was rapidly accepted around the world and which has since saved the lives of countless patients who were temporarily or permanently unable to eat. The success of this classic experiment in 1966 was the culmination of his lifetime scientific obsession with perioperative nutrition. As early as 1938, he reported in the *Archives of Surgery* "On the use of Lyophile Plasma in Correction of Hypoproteinemia and Prevention of Wound Disruption." Forty-two years later at Dr. Rhoads's 80th birthday celebration, Francis Moore, former Chairman of Surgery, Peter Bent Hospital, told the rest of the story:

> I would like to focus on his tenacity in science and his consistent exhibition of two scientific tastes that are of immense importance and have characterized Jonathan's work over the

decades. First is a taste for simplicity and directness, possibly Quaker in origin, and second a strong sense of what is important in the advance of human knowledge in the biomedical sciences.

Starting over thirty years ago, Jonathan became interested in nutrition. He wrote many articles on hypoproteinemia in rats, produced as a result of a low protein diet. Then a few years later he became interested in fostering nutrition by infusing lots and lots of useful soluble nutrients . . . [and] getting rid of all that extra water with a solute diuresis . . .

And then finally the team including Drs. Wilmore, Vars and Dudrick produced that simple experiment in growing puppies that gave the world modern intravenous nutrition, a new term, the "lifeline" and that masterly contraction in terms, "total parenteral alimentation." His were experiments that needed no statistics, no complexity; [they were] simple and direct; right to the point, and very, very significant. They didn't even need large numbers. They just showed that puppies grown on nothing but intravenous nourishment grew normally in every way. There was a sort of a new phenomenology in this, leaving no doubt in anyone's mind.

There are several things that have occurred in science during this century, in which all areas of biology and medicine owe a debt to surgery. There was the pump oxygenator (a Philadelphia product), allotransplantation of organs (for which Boston might claim some credit), certain aspects of the endocrine treatment of cancer (the Nobelist is with us tonight), microvascular anastomosis and use of lasers to repair the retina and the localization of functional areas in the cerebral cortex. To these epoch-making advances, the kind for which Nobel Prizes are awarded, we must add total intravenous feeding, the product of Jonathan's long and tenacious study.

Despite Jonathan Rhoads's preeminence as a clinician and as a surgical scientist, his contribution as a teacher may have been even greater. During his thirteen years as departmental chairman, his residency program graduated sixty-two surgeons who have served as faculty members in thirty-four different medical schools, twenty-eight as full professors and eleven as departmental chairman.

As a statesman of science and medicine, Dr. Rhoads was well known for his record of service to the National Research Council, the U.S. Public Health Service, the U.S. Congress and the Veterans

Administration. His most strategic input on behalf of federal support of cancer research came from his membership on the panel of consultants on the conquest of cancer, whose recommendations led to the National Cancer Act of 1971.

The esteem with which his colleagues regarded him and the service he provided to some sixty-five professional organizations is evidenced by the number of officerships he held. To mention only a few, those many of which he was president or chairman include: the American College of Surgeons, the American Philosophical Society, the American Surgical Association, the College of Physicians of Philadelphia, the Council of Medical Specialty Societies, the International Federation of Surgical Colleges, the International Surgical Group, the Philadelphia Academy of Surgery, the Philadelphia County Medical Society, the Society of Clinical Surgery, the Society of Surgery of the Alimentary Tract, the Surgical Infection Society, and the Society of Surgical Chairmen.

Many special awards came to him: the Distinguished Service Award of the American Cancer Society; the Strittmatter Award of the Philadelphia County Medical Society; the Joseph Goldberger Award of the American Medical Society for Clinical Nutrition (with Stanley Dudrick); the Citation of the Association for Academic Surgery; the Roswell Park Medal for Eminent Service to Profession and Humanity; the American Cancer Society National Award; the Distinguished Service Award of the Pennsylvania Medical Society; the Papanicolaou Award, the Medallion for Scientific Achievement, and the Flance-Karl Award of the American Surgical Association; the Distinguished Service Award of the American Trauma Society; the *Prix de la Societe Internationale de Chirurgie*; an Honorary Benjamin Franklin Fellowship of the Royal Society of Arts; the American Medical Association's Sheen Award for Scientific Accomplishment; the Franklin Medal of the American Philosophical Society; and the Cosmos Club Award. Additionally, several annual lectureships are named for him by organizations including the Philadelphia Academy of Surgery, the American Philosophical Society, the Department of Surgery of the University of Pennsylvania, and the College of Physicians of Philadelphia.

Surgical colleges of other nations, which have honored Dr. Rhoads with memberships, include those of Canada, England, Germany, Holland, India, Ireland, Poland, Scotland, and South Africa. He also holds honorary degrees from Duke University, Georgetown University, Hahnemann University, Haverford College, the Medical

College of Ohio at Toledo, Swarthmore College, Thomas Jefferson University, the University of Pennsylvania, and Yale University.

As versatile as Rhoads was in surgery, his breadth exceeds the scope of the medical profession, to an extent rarely if ever paralleled by a surgeon. From 1956 to 1959 he was Provost of the University of Pennsylvania. He served on the Board of Public Education of the City of Philadelphia from 1960 to 1981. He has been on the Board of Trustees or Executive Committee of Bryn Mawr College, the Westtown School and Haverford College, chairing the latter. He has served on the Council of the American Academy of Arts and Sciences and from 1976 to 1984 was President of the American Philosophical Society, the oldest and most exclusive of the country's learned societies, which was founded by Benjamin Franklin in 1743.

As remarkable as his earlier accomplishments were, Dr. Rhoads may have become even more admired for the vitality and productivity he exhibited during the last several decades of his life. He stopped operating when he turned 80, although the day before this he was fully capable of performing the Whipple procedure on his list. In some respects his activities subsequently seemed almost to increase. Until the time of his death he remained the most dedicated attendee of the conferences of not only local, but also national and international societies. At all of these he participated actively in discussion. He continued to lecture and serve as a visiting professor frequently and never accepted emeritus status at the University of Pennsylvania (mandatory for all others at age 70). He continued to edit the journal *Cancer* until 1991. Much of his time during his later years was taken by his duties as a trustee in the General Motors Cancer Research Foundation and as chairman of its Awards Assembly. One reason he enjoyed this position was the value he placed on the opportunity General Motors provided him to use new models of their automobiles. It was no surprise when only a few years ago he selected a Corvette, since he always fancied fast cars and drove them with frightening abandon.

In 1990, Dr. Rhoads married Kathryn Evans Goddard. Kitty, like Terry, is a pediatrician and is the widow of David Goddard, who had succeeded Rhoads as Provost of the University of Pennsylvania. This provoked the comment by one wag that he only married pediatricians and she only provosts. Kitty is Jonathan's distant cousin but as he said with a twinkle in his eye, they were not concerned over consanguinity. In many ways after this marriage, Dr. Rhoads seemed even more youthful and vigorous than before, as he and Kitty traveled

all over the world (usually for him to preside or speak at scientific meetings).

A few of the personal qualities for which Dr. Rhoads was so widely known were consistency, integrity, patience, persistence, self-discipline, and wisdom. These are qualities to which we all aspire and they no doubt helped him to lead a good and useful life. But in the memoir of a recently departed, revered individual a list of such characteristics don't seem particularly unusual or even interesting. In fact, some people who had only a casual exposure to Jonathan Rhoads thought that he wasn't a very interesting person. Those better acquainted with him knew otherwise.

I believe that some of his well-known, somewhat reserved persona was a well-studied façade behind which there was a quite different, complex, and totally fascinating person. In fact, some of the qualities attributed to him were probably skills rather than innate personnel characteristics. We know from reading between the lines of such otherwise obscure sources as the 1927 Haverford Yearbook that the young Jonathan's exuberance was frequently expressed in his college dormitory by disruptive practical jokes. His athleticism and his spontaneity (even impulsiveness) led him during a summer trip to Europe to swim the Bosporus (from Asia to Europe). Later in life, as he navigated the even more treacherous waters of academic and political life, Dr. Rhoads learned that a steadier style was necessary. My guess is that after that, his playful or unpredictable side was seen mainly by his family. But more than occasionally others were treated to a glimpse of it, such as when he got behind the wheel of a fast automobile or after a small dinner party when he would tell one or a series of jokes from the vast store his incredible memory allowed him to catalogue. Some of these were of questionable taste. Or on one of those rare occasions in the operating room when, provoked by some unfair and totally unacceptable twist of fate, he would momentarily lose control and hurl an instrument or sponge to the floor.

At other times the steadier qualities (or skills) worked best. In recent decades, long after the trappings and intrinsic power of chairmanships and presidencies were no longer available to him, it became easier to see how effective his methods were. It was an educational experience to watch him work his magic at a scientific meeting, when many people thought he was asleep, or even more so in a committee or board meeting. He usually waited until others were finished before he spoke. He exhibited his characteristic self-discipline in not only listening to what the others had to say, but

also by carefully acknowledging the merits of opinions which were at variance with his own. He even offered to compromise on one or two (albeit, usually minor) aspects. He exhibited patience in exhaustively summarizing the pros and cons of the issue, but in such a way that the assembled group understood them so clearly that they recognized the wisdom of his choice of action. He always won out. His effectiveness with this method was so consistent that many who studied under him (and thus studied him) tried to emulate it—but never with the same kind of success.

Those who had the honor of caring for Dr. Rhoads during his final illness had a chance to see several other qualities, which were *bona fide* intrinsic characteristics, ones which probably can't be learned: courage and consideration for others. He was reluctant to acknowledge the inevitability of his demise from gastric cancer until every possible treatment was considered. But after he came to terms with this, he was determined to delay the outcome until he was ready for it. He was the model of a courageous patient. He had decided that whatever the cost in personal comfort, he would continue for as long as possible to be useful to his family, his institutions, and his colleagues. He carried on with a virtually full schedule of meetings and correspondence until a few days before his death. Although he was always compliant and considerate of his doctors, they understood who was calling the shots. It was especially fitting that the extension of his life by several months (which he greatly valued) was made possible after he could no longer eat, by total intravenous nutrition, the treatment he and his colleagues had devised. It was also appropriate that his last days were spent in the Hospital of the University of Pennsylvania's Rhoads Pavilion, which the university had named for him, under the care of a group of physicians, which included members of his department and his own family.

Memoir: Lewis Lemon Coriell, M.D., Ph.D., 1911–2001

David P. Beck, Ph.D., and Amy E. Leach

Recollections of a multi-dimensional man require many commentators for accuracy. Even the closest and longest of friends can only provide an incomplete picture, and this dilemma is especially true of a man with the breadth, talents, and accomplishments of Lewis L. Coriell. His medical career traversed extraordinary advances in health care, and his scientific career included many contributions to those improvements.

Our association with Dr. Coriell has been through the research institute, the Coriell Institute for Medical Research, that he created to be the home for his research and that of many other scientists who have followed in his footsteps. Aside from family, of course, this institute and the research he conducted in it were certainly Dr. Coriell's life's *chef d'oeuvre*. To accomplish this project, Dr. Coriell brought to bear not only his scientific and medical acumen, but also his ability to navigate the political shoals of the State of New Jersey; the press and the political system; and the philanthropic impulses of the business community, from those who wanted improved healthcare for coming generations, and those who were captivated by the earnestness and sincerity of this gentle man.

The origins of the Coriell Institute were in the work that he did on the gamma globulin field trials for polio. From this success, Dr. Coriell and his colleagues reasoned that, just as it was possible to create vaccines for viruses like mumps and measles, it ought to be possible to create a vaccine against polio. [Indeed, Dr. Coriell mused on occasion that the epidemics of polio in more recent public health history might be products of improved sanitation. Just as this improvement virtually removed exposure to diphtheria as a public health scourge, so too it reduced the natural passive immunity from exposure to the polio virus in the environment.] Dr. Coriell further reasoned that, since there did not appear to be a natural animal reservoir for this human virus, he would have to create one by developing a culture of human cells that could be infected with the polio virus.

Dr. Coriell's initial experiments were conducted with a less dangerous virus, the chicken pox virus, which did indeed proliferate in his cell culture system. After a visit to Dr. Coriell's laboratory, Dr. John Enders of Harvard grew the polio virus using the Coriell cell culture system. Many were disappointed that Dr. Coriell did not share in the 1954 Nobel Prize which was awarded for the conquest of polio, although he was fêted and funded extensively by the Infantile Paralysis Foundation and later the March of Dimes for his work.

Dr. Coriell's research institute was founded in 1953 on the grounds of the old Camden Municipal Hospital for Contagious Diseases in New Jersey. Dr. Joseph Stokes, Dr. Coriell's supervisor during his residency at the Children's Hospital of Philadelphia, had asked him to head this hospital. While demonstrating his administrative and managerial abilities by making substantial improvements in this hospital, Dr. Coriell also established a research laboratory, then called the South Jersey Medical Research Foundation. The institute laboratory was built on the grounds of the Municipal Hospital, where it remained, even after the hospital was torn down, through eight laboratory additions. A new laboratory building was opened about a mile away in 1989 near the Cooper Hospital and the Robert Wood Johnson Medical School in Camden.

Through the early years, research blossomed at the Institute, although finding funds was always a struggle. Dr. Coriell recruited outstanding scientists to work with him, including individuals such as Drs. Warren Nichols, Arthur Greene, and Daniel Moore. Research programs included cancer virology and cytogenetics. Throughout this time, Dr. Coriell continued to develop human cell culture to support his research programs.

Dr. Coriell's expertise and success in human cell culture became well known, and his contributions to this technology include procedures, media formulations, glassware, cryogenics, and contamination prevention. Most notably in this latter category is the now ubiquitous laminar flow hood, a device that isolates cell cultures from the outside air. The first production model of this invention, based on Dr. Coriell's design, still resides at his institute and was, until a few years ago, in service.

In 1964, the National Cancer Institute funded the first of the Coriell Institute's cell banks. In 1972, at the behest of internationally known scientists such as Drs. Harry Eagle and Frank Ruddle, this cell bank was continued as the Human Genetic Mutant Cell Repository, funded by the National Institute of General Medical Sciences (NIGMS). This cell collection has been funded by the

NIGMS ever since, and has proven to be a key resource in the human genome project and the larger effort to understand the functional complexity of the human genome. In 1974, the National Institute on Aging began another important bank, and over the years numerous other collections were established and continue to be established, resulting in the world's largest repository of human cells for use in research.

Even as he continued to develop new cell culture technology and apply it to new research projects and to new collections of cells for his and others' research, Dr. Coriell was positioning his institute for the future. Beyond the new technology, new facilities and infrastructure, and new research programs, perhaps the most important legacy that Dr. Coriell left for his institute was an attitude of excellence. Quality control and quality assurance were essential to this commitment for future growth. Little escaped his notice, and he insisted on rigor in following established procedures. Several key technologists who learned cell culture during the Coriell era still work at the institute in leadership positions. They form a link to the Coriell standards and style. These standards have positioned the institute for its growth and diversification into collaborative projects supported not only by the National Institutes of Health, but also by pharmaceutical and biotechnology companies and by voluntary health agencies.

Although neither of us worked directly for Dr. Coriell, we have known him for years (one of us since 1977), and quite quickly have picked up Dr. Coriell's expectations for quality and commitment. In retrospect, Dr. Coriell's ability to impart a sense of rigor and an expectation of quality may have been relatively easy. It may have come from the enormous respect and sense of loyalty that he engendered. Perhaps that is why the Coriell Institute has so many employees who have worked and remained at the Institute for more than twenty, thirty, and even forty years. One simply did not want to disappoint Dr. Coriell; one had to try to live up to his standards. This applied to everyone in his institute since everyone knew him personally. Dr. Coriell's kind of personal balance and equanimity made him an excellent physician, scientific leader, and businessman.

During his research career, Dr. Coriell authored over 200 scientific papers and book chapters. Beyond this, his works included bringing medical education to South Jersey, establishment of the New Jersey Commission on Cancer Research, and of course leadership of the College of Physicians of Philadelphia, among many others. Even in retirement he continued research, working on developing

disease-resistant strains of the chestnut tree, developing a collection of cells from people of great age for the institute's Aging Cell Repository, and planning a corollary aging epidemiology project.

As the institute reaches its 50th anniversary in the Fall of 2003, it has commissioned the writing of a book that will serve as a benchmark for the Institute's first fifty years. With a foreword written by Dr. Jonathan Rhoads, the impact of this story not only commemorates Dr. Coriell's life and accomplishments, but also places him within the larger framework of medical science in the Delaware Valley, across the nation, and within the international scientific community. The book interprets the history of science and medicine and details the political, social, and economic context for the development of scientific research in the region, offering perspectives of business leaders and activists in the 1950s and beyond who believed in the work of Dr. Coriell.

A legacy of leadership and accomplishment such as Dr. Coriell's will be more than just "remembered well." It is one that actually forms the foundation for many enduring structures that will contribute to the well-being of future generations. A Fellow of the College of Physicians of Philadelphia from 1973 to 2001, Dr. Coriell died on June 19, 2001, the day of his ninetieth birthday.

From the Archives

A Discovery of Historic Importance

Charles B. Greifenstein, M.S., M.A.

On June 28, 2001, Facilities Foreman Leroy Green called me down to the basement to show me some papers he had discovered locked in a lectern. The lectern had been stored in the vault on the second floor, moved to the Library workroom, and then moved downstairs when that space was needed. Old and nondescript, the lectern could have been thrown out, but Leroy heard the papers rattling inside, popped the lock, and called me. Inside were over eighty documents dating back to the founding of the College. Signatures of "Benjn Rush," "C. W. Peale," and "A. Hamilton" easily demonstrated the historical value of the find. For the College of Physicians it was the discovery of the decade, illuminating the early history of the College, its role in the national (and international) world of medicine—indeed, in the larger social and political life of the early Republic—and the College's importance locally.

The letters from Benjamin Rush, Alexander Hamilton and others help to flesh out the history of the College during its first twenty years. Of special interest are the Rush and Hamilton letters written at the time of the 1793 yellow fever epidemic in Philadelphia, which carried off perhaps 5,000 of a total population of 55,000. It was a health crisis of major proportions, and the physicians at the College were at the forefront of attempts to stem the epidemic. Rush of course became known for his advocacy of heroic therapeutics, massive doses of calomel and copious bloodletting being the highlights. The letter by Rush, dated 2 October 1793 and written to Fellow Samuel Powel Griffitts, states that he continues "to use mercury in large doses, with great success," viewing success only when the "evacuations" are "large and bilious."

Advocates of gentler therapy, usually involving cooling the patient, mild purging, mild stimulants, and no bloodletting, included such College Fellows as William Currie. Another advocate of milder

therapy was a friend of Alexander Hamilton's, Edward Stevens. In the cache of documents is a letter from Hamilton recommending Stevens as someone with a lot of experience with yellow fever. Stevens and Hamilton had known each other in the Caribbean (Hamilton's birthplace), and Stevens had recently successfully treated Hamilton and his wife. Hamilton was "in [his] own person a witness to the efficacy of [Stevens'] plan [of treatment]" and is persuaded that if pursued, the disease could be reduced "to one of little more than ordinary hazard." A letter from Stevens details his treatment.

The dispute over how to treat yellow fever had political dimensions. The "Federalist" treatment was supported by Hamilton, the "Republican" (i.e., Jeffersonian) by Rush. However the politics played out among the Fellowship of the College, Rush's treatment was viewed by many physicians as extreme, and Rush felt it necessary to resign from the College because of the dispute. Both the Hamilton and Stevens letters were printed in *The Federal Gazette* and *Philadelphia Daily Advertiser*. The College's copies are the only manuscript copies I have been able to locate.[1]

Another letter in the find is from the artist and museum developer Charles Willson Peale. Although known for his portraits and museum, Peale was also a scientist and inventor. One of his interests was health, especially food and hygiene. Peale invented a "Steambath" (for which he received a patent) that he thought had therapeutic value for "some complaints," as he says in his letter. He sent a Steambath to the College for examination. Peale also sent one to Pennsylvania Hospital and the old Almshouse, which became Philadelphia General Hospital. While Peale's letter to Pennylvania Hospital is known, the College's letter is not reproduced in the printed edition of Peale's papers.[2]

Although the documents discussed above have to be considered the highlights of the find, perhaps more significant for the history of medicine and of the College are those by the less famous, correspon-

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[1]Hamilton's letter has been printed in his collected papers, Harold C. Syrett, ed., *The Papers of Alexander Hamilton*, New York and London: Columbia UP, 1969, Vol. 15, June 1793–Jan. 1794, p. 331. With Stevens' letter it was printed in Stacey B. Day, *Edward Stevens: Gastric Physiologist, Physician, and American Statesman*, Montreal: Cultural and Educational Productions, 1969, pp. 83–86. Both refer to the *Gazette* as the source for the letters.

[2]Lillian Miller, ed., *The Selected Letters of Charles Willson Peale and His Family*, New Haven and London: Yale UP, 1988, Vol. 2: The Artist as Museum Keeper, 1791–1810, p. 315 n. and p. 1160.

dence that shows how international the world of medicine was at the turn of the 19th century. There are of course many case reports from resident Fellows. William Currie is represented by more papers—thirteen—than anyone else. He wrote on such topics as cynanche trachealis, fever, smallpox inoculation, and measles. Other Fellows who sent papers include Thomas Parke (rheumatism), Charles Moore ("the worthiness of Bucks County physicians"), Benjamin Say (a case of anthrax), Thomas Hewson (smallpox), and Michael Leib (gleet).

Physicians beyond Philadelphia also sent correspondence to the College. Some were Associate Fellows, such as James Tilton of Delaware, who urged the College to proceed with its plan for a U.S. pharmacopeia, and Isaac Senter of Rhode Island, who praised the usefulness of *Transactions* of the College. Physicians without direct links to the College also sent correspondence. William Baynham of Virginia sent a report of a case of extrauterine conception. Samuel Latham Mitchill of New York wrote about pulmonary consumption.

Of special interest is an account of "putrid sore throat" from James Durham, a black physician in New Orleans, sent to Benjamin Rush and presented at a meeting of the College on 4 August 1789. Durham was born a slave. During his life he was owned by more than one physician, who recognized his aptitude and mentored him in medicine. Eventually purchasing his freedom, Durham moved to New Orleans where he became known for his expertise in treating throat ailments. Rush, active in promoting the welfare of African-Americans, met Durham and a correspondence developed. Comparisons to Durham's letters in the Rush papers at the Library Company of Philadelphia show that the College's letter is not in Durham's hand. Other letters at the Library Company and minutes of College meetings make it clear that the case was Durham's; the origin of the found copy is unknown.[3]

Beyond Philadelphia and the United States, the College was a part of the international community of medicine. James Grant of Montego Bay, Jamaica, sent a paper on a gum extract found on the island. Another Caribbean physician, Stephen Kingston, sent a letter on yellow fever. A physician sent a paper on diseases in Batavia, Dutch East Indies (now Jakarta, Indonesia): another named Bodelio sent a paper, in French, about venereal disease in Calcutta, India.

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[3]Charles E. Wynes, "Dr. James Durham, Mysterious Eighteenth-Century Black Physician: Man or Myth?," *Pennsylvania Magazine of History and Biography*, v. 103, 1979, pp. 325–333.

The records of the College found in the lectern offer new insights into the history of College and the world of medicine at the turn of the 19th century. As an archivist, the find has given me an uncommon opportunity to explore that time and to preserve properly important documents in the institutional life of the College.

Notes on Contributors

Clyde F. Barker, M.D. is the Donald Guthrie Professor of Surgery at the University of Pennsylvania Medical Center. He served as Chairman of the Department of Surgery for 18 years beginning in 1983. A graduate of Cornell University's School of Medicine, he has published nearly 400 articles on surgery, transplantation, and related topics. He has been a Fellow of the College since 1976.

David P. Beck, Ph.D. is the President and Chief Executive Officer for the Coriell Institute for Medical Research. A cum laude graduate of Princeton, Dr. Beck received his doctorate in biochemistry from Johns Hopkins and was for three years a postdoctoral fellow at Harvard. He has been a Fellow of the College since 1993.

Charles Greifenstein, M.A., M.S. is Curator of Archives and Manuscripts at the Historical Library of the College of Physicians of Philadelphia. He received an M.A. in Literature from the University of Arizona and a Masters in Library Science from Drexel University.

Aaron S. Kesselheim is currently a combined M.D. / J.D. student at the University of Pennsylvania Schools of Medicine and Law, where he is a Franklin fellow and a James Wilson Scholar. He received his A.B. summa cum laude and Phi Beta Kappa from Harvard University in 1996. He has published on different aspects of medico-legal policy matters, including a chapter on end-of-life care in the I.O.M. text Improving Palliative Care for Cancer and an article on external appeals for managed care coverage denials in volume 149 of the Penn Law Review.

William L. Kissick, M.D., Dr.P.H. was present at the creation of the nation's Medicare program as a young policy aide in Washington, D.C. Currently an adjunct professor at Yale University, Dr. Kissick taught at both the Wharton School and the Medical School of the University of Pennsylvania for many years. A Fellow of the College since 1969, Dr. Kissick has testified before Congress on behalf of the College. He recently chaired the College Task Force on Presidential Health and the 25th Amendment.

Amy E. Leach is the Public Affairs Director for the Coriell Institute for Medical Research. She has a degree in English from the University of Delaware.

Marc S. Micozzi, M.D., Ph.D. is Executive Director of the College of Physicians of Philadelphia and former Director of the National Museum of Health and Medicine in Washington, D.C. He obtained his M.D. and Ph.D. in anthropology from the University of Pennsylvania and remains actively involved in medical anthropology. He is the editor of the first textbook on complementary medicine for physicians, now in its second edition.

Bert E. Park, M.D. is a practicing neurological surgeon and adjunct professor of history who has written numerous articles and two books on the illnesses of world leaders and historical figures: *The Impact of World Leaders* and *Ailing, Aging and Addicted: Studies of Compromised Leadership*. He also served on the Editorial Advisory Committee for the Papers of Woodrow Wilson at Princeton University.

Arlen Specter, J.D. is the senior U.S. Senator from Pennsylvania. He is the only person ever elected to a fourth Senate term in the history of the Keystone State. A former Philadelphia District Attorney, he played an important role as part of the Warren Commission staff investigating the assassination of President Kennedy. An Honorary Fellow of the College, the Senator recently published an autobiography entitled *Passion for Truth: From Finding JFK's Single Bullet to Questioning Anita Hill to Impeaching Clinton*.

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